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How counselling psychologists and psychotherapists experience working with clients diagnosed with schizophrenia: An interpretative phenomenological analysis

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How counselling psychologists and psychotherapists experience working with clients diagnosed with schizophrenia:

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by

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How counselling psychologists and psychotherapists experience working with clients diagnosed with schizophrenia:

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ABSTRACT

This study is concerned with the subjective experiences of therapists working with clients diagnosed with schizophrenia, and seeks to gain insight into what it feels like for practitioners to be in a therapeutic relationship with clients who experience hallucinations, delusions and other symptoms associated with schizophrenia. Six psychotherapists and counselling psychologists, all of whom have previously worked with clients diagnosed with schizophrenia, were interviewed. Interpretative Phenomenological Analysis (IPA) was chosen to generate rich interview data. Participants were asked about their experience of working with clients diagnosed with schizophrenia. Participants' narratives were analysed using IPA to identify common themes. The analysis resulted in twelve interrelated themes from which three master themes emerged. The first theme, 'The dark territory', explores the impact of chaos on the practitioner; participants noted that this type

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of work was experienced as part of the typical work of psychotherapists, yet simultaneously it felt alien and utterly chaotic, and was characterised by rich, powerful experiences that were alarming, especially at the beginning of the participants' careers. The second master theme, 'The symbiotic relationship', reveals how emotionally involved the participants are with their clients. This was evident in their protectiveness and affection towards their clients. All participants emphasised the beneficial value of psychotherapy with people diagnosed with schizophrenia, and which makes therapeutic relationship mutually beneficial. This study found that psychotherapists and counselling psychologists require specialist supervision and training. These are explored in the final theme – 'Containment'. Potential implications of the themes that emerged were explored. This study contributes to the literature on counselling psychology and schizophrenia, and to the understanding of how best to support therapists in working with this client group.

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INTRODUCTION

This study looks at the subjective experience of psychotherapists and counselling psychologists of working with clients diagnosed with schizophrenia. The subjective experience of being in contact with and trying to relate to someone diagnosed with schizophrenia in a therapeutic context is the focus here. The study begins by presenting schizophrenia as a diagnostic category. There follows an outline of the currently dominant paradigm and the impact of this view on availability of treatments, as well as a discussion of the psychosocial literature which offers an alternative view on understanding this condition. I also aim to introduce the reader to different views on using this controversial term in clinical practice. These introductory topics are presented to prepare the reader for the Results chapter where the importance of theory emerges as a salient aspect of participants' experience. An overview of various theoretical ideas and treatment options aims to make clearer what theories the participants might be referring to and how they position themselves in the debate on schizophrenia. This will also set the stage for the main aim of this chapter – to outline the literature on therapists' experience. The chapter concludes with the formulation of the research question and a rationale for choosing Interpretative Phenomenological Analysis to address this research question.

In this research the term 'client(s) diagnosed with schizophrenia' is used in order to avoid using stigmatising and pejorative terms such as 'schizophrenic'. The term 'diagnosed with' rather than 'clients/people with' is used to avoid giving the impression that everyone agrees that there is an underlying illness, when in fact this assumption is debated. The terms 'practitioner' and 'therapist' are used to define psychotherapists, psychoanalysts and counselling psychologists as a group.

Schizophrenia as a diagnostic category

A full apprehension of man's condition would drive him insane

(Becker, 1973, p. 27)

A detailed review of the history of schizophrenia is beyond the scope of this study; a quick sketch of the development of this diagnostic category in the last century will nevertheless be presented to introduce schizophrenia as a diagnosis. A detailed history can be found in other sources, such as Alexander and Selesnick (1996). Read, Mosher and Bentall (2004), reflecting on the history of 'madness', argue that essential characteristics of the relationship between the so called 'mad' and the 'sane' emerge, which include persecution, social control and violence; these later became camouflaged as treatment. In 1893 the seminal figure of psychiatric history, Emil Kraepelin, introduced the label 'dementia praecox' (an early term for schizophrenia), claiming that he had discovered an incurable, degenerative illness; this claim has been questioned ever since. For example, Harry Sullivan writes: "The Kraepelinian diagnosis by outcome has been a great handicap, leading to much retrospective distortion of data, instead of careful observation and induction" (1927, p. 760). Kraepelin repeatedly re-categorised the symptoms and generally ignored his patients' subjective experience in favour of objective, external data (Jennings, 1987). Schizophrenic language at that time was considered meaningless gibberish.

Emil Bleuler (1911, 1924), the second founder of modern psychiatry, admitted the lack of evidence for symptoms, prognosis, causes or treatment for schizophrenia. Despite this, the notion of a biogenetic illness called schizophrenia was accepted by the psychiatrists of the developed world as if it were scientific fact. The conviction predominated that 'madness'

was genetically inherited, leading to the ‘dark era’ of psychiatry, when for eugenic reasons sterilisation was practiced and the usefulness of these patients’ lives was openly doubted. In 1939 mass murders began, aimed at improving ‘race hygiene’, at first by starving patients to death and then by gassing them in mental hospitals. ‘Euthanasia’ or ‘mercy killing’ led to a total number of over a quarter of a million patients killed with carbon monoxide in Germany alone (Wertham, 1966). Murders were administered by psychiatrists and hospital staff. Peters (1999) wrote about Nazi psychiatrists breaking their Hippocratic Oath: “Nazi psychiatry was not different in all respects from classical psychiatry. A shared belief between them was that endogenous psychoses were somatic, with mainly genetic causes, and they also shared a therapeutic nihilism” (p. 89).

The search for classification and diagnosis continued throughout the 20th century up until the present, and led to the development of the WHO and DSM systems for classification of mental diseases. The diagnostic and statistical manual of mental disorders, now in its fifth edition, commonly referred to as DSM-V views schizophrenia as a form of client presentation characterised by disintegration of thought processes and of emotional responsiveness. It defines schizophrenia as a heterogeneous clinical syndrome whereby individuals with this diagnosis vary substantially on most features (APA, 2013). In DSM-V schizophrenia is included as part of the schizophrenia spectrum along with other psychotic disorders, together with related diagnoses such as brief psychotic disorder, schizotypal disorder, delusional disorder, schizophreniform disorder, schizoaffective disorder, catatonia and substance induced psychotic disorders. Diagnostic criteria for schizophrenia require two (or more) of the following symptoms, present for 1 month (or less if successfully treated); and at least one should be 1, 2 or 3.

1. Delusions (bizarre or false beliefs held with absolute conviction despite evidence to the contrary. Examples of delusions include persecutory, referential, grandiose, erotomanic, nihilistic and somatic);
2. Hallucinations (perception-like experiences that occur without an external stimulus, they are vivid and clear and not under voluntary control);
3. Disorganised speech and thinking (such as frequent derailment, loose associations, tangentiality, incoherence or 'word salad');
4. Grossly disorganised or abnormal motor behaviour including catatonic behaviour (such as mutism, stupor, catatonic excitement, etc.);
5. Negative symptoms (including diminished emotional expression, avolition, alogia, anhedonia and asociality).

In order to meet the criteria, a person's level of functioning in at least one major area of life should be markedly impaired (e.g. work, interpersonal relationships or self-care). Signs of disturbance must be present for at least 6 months. For full diagnostic criteria please refer to 295.90, DSM-V (APA, 2013).

Controversies around the label and the causes

Your label is a reality that never leaves you; it gradually shapes an identity that is hard to shed

(Leete, 1989, p. 199)

Controversy has become almost integral to the concept of schizophrenia; debates are ongoing about whether the illness, as defined by the concept, actually exists, whether it is a medical or a social problem and what is the best way to treat it. An increasing number of

researchers challenge the diagnosis of schizophrenia, and suggest that it is not a valid object of scientific inquiry. Bentall, Jackson and Pilgrim (1988) reviewed the published research, casting doubt on: (i) the construct's reliability, (ii) the construct's validity, (iii) the construct's predictive validity and (iv) the aetiological specificity of the schizophrenia diagnosis. They argue that alternative methods of studying psychosis should be adopted; they discuss such alternatives as the development of empirical methods of psychiatric classification and the study of individual symptoms. The reliability and validity of schizophrenia as a concept has been further questioned in a number of comprehensive reviews (Bentall, 2003; Boyle, 1993; Szasz, 2011).

Pilgrim (2000) writes that "the fundamental question of poor or absent validity remains unanswered" (p. 302), and argues that diagnostic systems such as DSM or ICD have no advantage over ordinary language descriptions of 'madness'. One clinical psychologist, Read (2004a), writes that "the construct, as employed by clinicians and researchers all over the world, remains disjunctive and therefore scientifically meaningless" (p. 46). An American psychiatrist, James (1996), argues that the term 'schizophrenic' should be considered "an unscientific and unprovable nosological construct, which has hampered the successful resolution of chronic psychosis and has outlived its usefulness in the lexicon of modern psychiatry" (p. 148). The International Network for Training, Education and Research into Hearing Voices (INTERVOICE, 2013) also promotes the abandonment of this label as unscientific and stigmatising; it argues that the label has outlived any usefulness, and that it is extremely damaging to those to whom it is applied. Walker (2006) suggests that terms such as 'schizophrenia' and 'mental illness' only exist by consensus, and persist by convention.

Szasz (2011) views the diagnoses as fabrications that are borderline abusive in terms of treatment. In his book *The Myth of Mental Illness* (1961) Szasz attacks psychiatric diagnoses and strives to recast mental illness from a medical problem into a linguistic-rhetorical phenomenon, arguing that metal illness is a metaphor. The history of medicine has shown that a number of mental illnesses have been identified as manifestations of somatic disease (such as beriberi, neurosyphilis or brain tumours); such discoveries move mental illnesses from the realm of psychopathology into the realm of neuropathology. Furthermore, he argues that bodily diseases have causes such as infectious agents or nutritional deficiencies; such causes can be treated and cured, whereas persons diagnosed with mental diseases "have reasons for their actions that must be understood; they cannot be treated or cured by drugs ... but may be benefited by persons who respect them, understand their predicament and help them to help themselves overcome the obstacles they face" (Szasz, 2011, p. 181). Therefore, the 'symptom' does not just exist out there, like a virus, and attacks the body, but has a purpose for emerging; and, by existing, the symptom is trying to achieve some goal. Furthermore, Szasz (2011) argues that psychiatry is 'pseudoscience':

> *According to pathological-scientific criteria, disease is a material phenomenon, a verifiable characteristic of the body, in the same sense as, say, temperature is verifiable characteristic of it. In contrast, the diagnosis of a patient's illness is the judgement of a licensed physician, in the same sense as the estimated value of a work of art is the judgment of a certified appraiser*. (p. 181)

He argues that medicalisation of the soul and of personal suffering intrinsic to life dehumanises the nature of existence, and that the medical model offers psychiatry a

protection that is used both to violate individual freedom and autonomy and to exercise social control (Szasz, 2011).

R.D. Laing challenged the psychiatric diagnosis of mental illness due to the deviation of the diagnostic process from the traditional medical model. Unlike other medical conditions, where examination and ancillary tests traditionally precede the diagnosis of possible pathology, the diagnosis of mental illness is made, he argued, based on behaviour, and tests only occur after the diagnosis, if at all (Laing, 1971; Kotowicz, 1997). Thus, mental illness is diagnosed by conduct, but treated biologically. He maintained that schizophrenia is "a theory not a fact". Laing re-evaluated the importance of environment in the aetiology of schizophrenia; he insisted that the environment plays a crucial rather than an accidental role (i.e. a trigger of disease). Finally, Laing noted the value of the content of psychotic behaviour, seeing it as a meaningful expression of distress delivered through a language of personal symbolism which can only be understood from within the situation. According to Laing, behaviours of people diagnosed with schizophrenia are not signs of a disease, but expressions of their existence. Thus, one "does not have schizophrenia, but one is schizophrenic" (Laing, 1960).

In *Sanity, Madness and the Family* Laing and Esterson (1964) present eleven case studies that explore the contribution of the family to clients' pathology, pointing out that symptoms of people diagnosed with schizophrenia are intelligible. The authors explore to what extent clients' experiences and behaviour are intelligible in light of the praxis and process of the family nexus. They report that the families of individuals diagnosed with schizophrenia are characterised by contradictory attributions and inconsistencies, secret alliances, double standards and insincerity, where the child is subject to constant confusion and mystification. Laing and Esterson highlight parents' inability in such

families to allow the child to differentiate him or herself and become individualised by establishing his or her own identity and autonomy. They note that, often, those closest to the client deny the client's experiences, attributing his or her behaviour to illness.

Symptoms associated with schizophrenia are frequently found in other psychiatric disorders, such as bipolar disorder (Crow, 1990) and dissociative disorder (Ellason & Ross, 1995). These findings come from a quantitative study examining the questionnaire data (Positive and Negative Syndrome Scale) administered to groups of patients with these diagnoses. Bentall (2004) compares diagnostic classification to astrology, where the future cannot be accurately predicted and generalisations are meaningless (for example, the statement that schizophrenia is a result of an interaction between genes and the environment), and where certain claims (such as that schizophrenia is a disease of the dopamine system) are unsubstantiated. He also suggests an alternative to the Kraepelinian incoherent label: complaint-oriented research. Research looking independently at specific psychotic complaints has revealed the following correlations: thought disorder was associated with exposure to caregivers who communicate incoherently (Wahlberg et al., 1997) – this adoption study looked at the questionnaire data from patients and their foster parents; paranoid symptoms were associated with exposure to victimisation and discrimination (Bhugra, Leff, Mallett & Leff, 1999) – a literature review of the UK studies on schizophrenia among the African-Caribbeans; hallucinations were associated with childhood traumas (Hammersley et al., 2003) – an empirical study looking at the correlation between trauma and auditory hallucinations.

There are passionate debates around the causes of schizophrenia. Overall, biological psychiatry implicates brain imbalances of neurotransmitters, such as dopamine and glutamate, as causes of schizophrenia. Subtle differences in the structure of individual

brains, as well as genetics, are used to biomedically explain the aetiology of schizophrenia. Family, twin and adoption studies all provide evidence for the genetic basis of schizophrenia. However, Leo and Joseph (2002) and Joseph (2004a) provide critical analysis of such evidence, revealing a number of serious methodological issues, such as the equal environment assumption in twin studies and the selective placement issue in adoption studies, which potentially confound and even negate the results of those studies.

Quantitative genetic research looking at the interaction between the symptoms of schizophrenia and particular genes is inconclusive. For example, Williams et al. (1999) looked at 196 sibling pairs diagnosed with DSM-IV schizophrenia and concluded that "common genes of major effect ... are unlikely to exist for schizophrenia" (p. 1729). Collip et al. (2013) suggest that individuals who are carriers of the A allele of the FKBP5 gene are more likely to have psychotic symptoms. However, Wigman et al. (2012) did not find a more broadly defined gene-trauma interaction in the development of psychosis.

Atwood, Orange and Stolorow (2002) argue that explaining psychotic experiences in terms of internal factors (the biological/vulnerability model) omits the important role of intersubjective fields. According to the biological model, some vulnerability exists within the mind and is independent from the world. This clear distinction between I and non-I is an objectivist assumption that leads to oversimplifying reductionism, because it assumes that the mind can exist in isolation from the world (p. 289).

Theories of pathological brain anatomy and biochemistry have been challenged, amongst others, by Bentall (2003), Copolov and Crook (2000), Lewontin, Rose and Kamin (1984), Mclaren (2000) and Siebert (1999). The biological changes in the brain, which are often uncritically assumed to be primary causes, can equally be a result of other influences. Research has identified a number of risk factors for schizophrenia and psychosis. In a

review of neurodevelopmental research Read, Perry, Moskowitz and Connolly, 2001 report that brain changes found in severely traumatised children are the same as those found in people diagnosed with schizophrenia (); Putnam and Trickett (1997) reported a similar correlation for PTSD based on a quantitative longitudinal study. Maltreatment and early adversity are associated with early psychotic experiences; evidence for this statement comes from a systematic review and meta-analysis of risk factors conducted by van Os et al. (2008), quantitative longitudinal study by Arseneault et al. (2011) and a correlational study by Cutijar et al. (2010). A meta-analysis of different studies exploring the maltreatment-psychosis link points to the fact that childhood maltreatment is a risk factor for psychosis in adulthood (Varese et al., 2012). A correlational study found that 52% of female inpatients suffered parental violence (Heads, Taylor & Leese, 1997). Another study found that 72% of inpatients who suffered both childhood physical and sexual abuse experienced hallucinations (Read & Argyle, 1999).

There are a number of pathways that lead from early maltreatment to psychosis; for example, the below mentioned correlational studies report the following independent factors which might mediate the association between maltreatment and psychosis, such as genetic susceptibility (Asarnow et al., 2001), immediate biological consequences of maltreatment (such as head injuries) leading to brain damage (Kim, 2008), increased likelihood of being victimised in adulthood (Korkeila et al., 2010), insecure attachment (Tait, Birchwood & Trower, 2004), social isolation (White et al., 2000), chronic use of high-potency cannabis (Di Forti et al., 2009) and substance abuse (Whitfield et al., 2005). In their meta-analysis of sixteen studies published between 1968 and 2012, Beards et al. (2013) reported that exposure to stressful adult life events was associated with increased risk of psychotic disorder and subclinical psychotic experiences. They cautioned,

however, that the methodological quality of the majority of studies was low; therefore, the results needed to be interpreted with caution.

The research cited above emphasises the importance of extreme psychological trauma in the aetiology of schizophrenia. However, it is important to note that some individuals may respond to trauma by dissociation, rather than by developing psychosis. One way of explaining this is the intrinsic resilience of the mind – ego strength. Atwood, Orange and Stolorow (2002) point out that the nature of trauma itself plays a crucial role. They argue that trauma which leads to psychosis (as opposed to dissociation) is the one that "annihilates … [and] subverts the person's whole way of making sense of his or her life and attacks sustaining connections to the human surround at their most fundamental level" (p. 303).

Correlational studies suggest that poverty and class (Kohn, 1976), living in urban areas (Pedersen & Mortensen, 2001), being an ethnic minority group (King et al., 1994), suffering a racist physical attack (Karlsen & Nazroo, 2002) and having a same-sex partner (Gilman et al., 2001) are all significant risk factors for schizophrenia, thus exposing a robust link between power relationships in society and individual psychopathology. Karon (1992) argues that, in order to be effective, therapists working with individuals diagnosed with schizophrenia must be able to confront the ugliness of economic, racial, sexual, ethnic, religious and gender discrimination which contribute to the development of schizophrenia.

Family issues, such as expressed emotion (hereafter EE) in the family, have clear implications for the development of schizophrenia and related diagnoses. EE is a measure of hostility, criticism and emotional over-involvement. A projective study over 15 years, the UCLA Family Project, found that, where adolescents rated their families as low in EE,

none of them received a diagnosis of schizophrenia or narrow-spectrum schizophrenia later in adulthood, and only 6% were diagnosed with broad-spectrum schizophrenia, whereas for adolescents who rated both parents as high in EE the rates were as follows: 73% broad-spectrum, 45% narrow spectrum and 36% definite schizophrenia (Goldstein, 1987). Communication deviance, defined as a tendency to speak in a way that makes shared meaning difficult or impossible, was consistently found to be higher among the parents of people diagnosed with schizophrenia (Miklowitz & Stackman, 1992), and high levels of communication deviance may precede the onset of serious psychotic disorders (Nugter et al., 1997).

This section has pointed out that the label 'schizophrenia' remains controversial and, although widely used as a diagnostic category, is questioned by a large number of clinicians and researches. Moreover, the passionate debates about the causes of this 'condition' are ongoing.

Approaches to the treatment of schizophrenia

The most serious side effect of medication here is the temptation for the physician to let the drug be enough

(Leader, 2011, p. 329)

Currently, the National Institute of Mental Health (n.d.), a component of the U.S. Department of Health and Human Services, defines schizophrenia as "a chronic, severe, and disabling brain disorder", stating that the disorder is caused by the interaction of genes with the environment, such as "exposure to viruses or malnutrition before birth, problems during birth, and other not yet known psychosocial factors", and that "the brains of people with schizophrenia look different than those of healthy people". The National Institute for

Health and Care Excellence (hereafter NICE) offers a less certain and radical explanation of the aetiology of schizophrenia and psychosis: “It is known that there are a number of genetic and environmental risk factors for developing psychosis and schizophrenia, but there remains uncertainty about how these factors fit together to cause the disorder” (NICE, 2014).

This current biomedical view is supported by the pharmaceutical industry, which dismisses the role of psychosocial factors, allocating to them at best the role of a trigger, and ignoring the existing research into them, stating that they are ‘not yet known’. Consistent with the biomedical view is the idea that medication seems the only reasonable treatment for the ‘brain disorder’. This position also implies that people diagnosed with schizophrenia will not benefit from telling their story and working through their subjective experience of suffering. Overemphasising biology and genetics leads to increased research into faulty genes, medication and screening for vulnerability. Unfortunately, such a view suggests that little can be done to prevent it. Read, Mosher and Bentall (2004) argue that, “Rather than lobby governments to fund primary prevention programs that could improve the quality of life for children, adolescents and their families, biological psychiatry gives politicians a perfect excuse for doing nothing” (p. 4); thus, they argue, “the experts of the day often camouflage the socio-political function, and the damaging nature, of the ‘treatments’ behind theories that the people concerned have personal defects that are ameliorated by the ‘treatments’” (p. 9).

Before the advent of psychiatric medication, the main treatment approach for schizophrenia was psychodynamic. In the 1950s the development of antipsychotic medication marked the beginning of a biochemical approach that was predominant for decades. However, lately there has been a subtle shift back to offering psychotherapy to

people diagnosed with schizophrenia (Horowitz, 2006). The NICE guidelines provide detailed guidance on services for people diagnosed with schizophrenia, from initiation of treatment to promotion of recovery. Currently, antipsychotic medication and brief psychological interventions – particularly family intervention and individual CBT – are the most recommended forms of treatment for schizophrenia. The NICE guidelines indicate that psychological therapy, CBT and family therapy should be offered to every individual diagnosed with schizophrenia; art therapy can also be considered as an option. Psychoanalytic, psychodynamic and adherence therapy, counselling and supportive psychotherapy are not recommended (NICE, 2014).

Antipsychotic medication is the most common treatment for schizophrenia and psychosis. However, Ross and Read (2004) argue that both conventional and atypical antipsychotics have adverse side effects which often outweigh the therapeutic effects of the drugs. Moreover, they argue that being prescribed medication communicates to the patient that his or her problem is biomedical, thus reducing the person's motivation to engage in thinking about his or her life history and current circumstances which have contributed to and potentially caused the problem, thus promoting pessimism and avoidance by emphasising that people with schizophrenia are categorically different. Use of medication is actively reinforced by pharmaceutical companies, which also sponsor psycho-education, convincing the public to adopt the biological paradigm; Moynihan, Heath and Henry (2002), in their article 'Selling sickness: the pharmaceutical industry and disease mongering', write that "Pharmaceutical companies are actively involved in sponsoring the definition of diseases and promoting them to both prescribers and consumers. The social construction of illness is being replaced by the corporate construction of disease" (p. 886).

Electroconvulsive therapy (ECT) was invented to treat schizophrenia; although nowadays it is used mainly for depression, schizophrenia was recommended by the APA “as the second most common diagnostic indication for ECT” (APA, 2001, p. 16). This treatment has significant adverse side effects, such as memory loss, brain damage and risk of death; moreover, its effectiveness seems to be temporary and, overall, questionable (Read, 2004b). As Brody (1952) puts it, lobotomy, ECT and medication are “brain-destructive therapies” (p. 75), which are designed to ‘treat’ people without having to understand them and to control and manage their disturbing behaviour.

Alternatives to medication have been explored in recent research. Non-hospital interventions with first-episode psychosis that offer psychosocial treatments with either no or low-dosage drug regimes were implemented and researched in such projects as the Soteria Project (Bola & Mosher, 2003), the Soteria Bern Project (Ciompi & Hoffmann, 2004) and the Finnish API Project (Lehtinen, 2001). Although diverse in a number of ways, these three projects aimed to minimise the use of medication and labelling, and all three demonstrated that early psychosis can be successfully treated without, or on low-dose, antipsychotic medication.

Psychotherapeutic theories take a different view on the aetiology of schizophrenia and psychotic experiences. There are a number of different approaches to understanding the symptoms and suggestions of what is helpful, but they all revolve around the belief that the symptoms are meaningful and have a purpose, and that interpersonal factors are implicated in the causes of schizophrenia. Due to space limitation and the large number of psychotherapeutic approaches to the treatment of schizophrenia it is beyond the scope of this thesis to provide a comprehensive review of all existing psychological theories of schizophrenia, the views on the central conflict and the range of therapeutic goals. A

number of such reviews are available; for example, psychoanalytic psychotherapy was reviewed by Sherry (1982), CBT and cognitively-oriented approaches for schizophrenia by Tai and Turkington (2009), and other approaches reviewed in Read et al. (2004).

Cognitive behavioural therapy for schizophrenia focuses on generating less distressing explanations for psychotic experiences, not on eliminating those experiences, and often recognises that psychotic experiences may serve a function. Dunn (2002) proposed to target clients' emotional distress caused by hallucinations or delusions and their inability to cope with these experiences. CBT for schizophrenia was first described by Beck (1952); it has evolved since then, and is widely used for treating schizophrenia and psychosis (Chadwick, Birchwood & Trower, 1996; Fowler, Garety & Kuipers, 1995; Kingdon & Turkington, 1994). Current quantitative research on the effectiveness of CBT suggests that, when compared with standard care, CBT is effective in reducing rehospitalisation rates by up to 18 months (NICE, 2014). NICE recommends CBT as one of the core interventions for individuals diagnosed with schizophrenia (NICE, 2014). Further reports of encouraging results for psychotic symptoms come from e. g. Christodoulides et al. (2008), Farhall et al. (2009) and Tai and Turkington (2009).

Research on the efficacy of psychodynamic psychotherapy has produced mixed findings. NICE guidelines (2014) do not recommend psychodynamic approaches, due to lack of evidence for their effectiveness in terms of symptoms, functioning and quality of life. However, they acknowledge that psychodynamic principles should be used by healthcare professionals to help them understand the experiences of people with schizophrenia, including the therapeutic relationship. Moreover, they note that the majority of studies included in their review assess the efficacy of classic forms of psychodynamic/analytic

psychotherapy. As these approaches have evolved in recent years, further research trials are warranted to assess the efficacy of newer forms of these psychotherapies.

There are vast differences of opinion about the effectiveness of psychotherapy with people diagnosed with schizophrenia. In striking contrast to the conclusion presented in NICE guidelines, a number of researchers reported findings in support of psychodynamic psychotherapy. Karon and VandenBos (1972), in the Michigan State Psychotherapy project (using mixed methods design), evaluated the effectiveness of psychoanalytic psychotherapy with clients diagnosed with schizophrenia. They found that psychotherapy produces significantly greater patient change than medication, and is particularly effective in changing the thought disorder, improving overall clinical status and decreasing hospitalisation. Medication, when used as adjunct to psychotherapy, made behavioural control easier; however, it slowed down the underlining change, suggesting that medication is only useful as a temporary rather than a permanent adjunct.

Another successful therapy project was conducted on an experimental ward of a psychiatric hospital (Deikman & Whitaker, 1979), where a purely psychological treatment regimen was instituted. The project resulted in decreased need for re-hospitalisation, and a reduced incidence of suicides, suicide attempts or elopements as compared to a fully staffed ward practicing psychopharmacology, which had three suicides in the same period. The authors concluded that the therapeutic approach is superior in long-term, cost-benefit effectiveness to the prevalent ‘revolving door’ programs which emphasise medication and ‘dischargeability’.

Malmberg and Fenton (2001) conducted a meta-analysis of existing research, and concluded that the methods employed in the reviewed studies were too poor to enable them to determine whether individual psychotherapy is efficacious for people diagnosed

with schizophrenia. In response to this inconclusive study, Gottdiener & Haslam (2002) conducted another meta-analysis, reviewing 37 studies published between 1954 and 1999, and concluded that individual psychotherapy, with or without antipsychotic medication, is an effective treatment for schizophrenia. In support of this view, a diverse group of analysts who worked psychoanalytically with psychotic patients demonstrated that patients diagnosed with psychosis can make remarkable recoveries through psychoanalytic treatment (Garfield, 2011). The value of psychodynamic psychotherapy in the treatment of schizophrenia and other psychoses, particularly during the early phase of illness, is supported by several quantitative studies, such as Bachmann et al. (2003) and Gleeson et al. (2003). Some older studies, such as Benedetti and Furlan (1987), Karon (1989) and Karon and Vandenbos (1981) also report that psychoanalytic psychotherapy is an effective treatment for schizophrenia. It is beyond the scope of this introduction to provide a comprehensive review of all studies on the efficacy of different types of psychotherapies for schizophrenia. A few have been presented above, but the reader is referred to Fenton (2000) and Read et al. (2004) for further reviews.

A number of prominent psychotherapists and researchers who worked with people experiencing symptoms associated with schizophrenia include Carl Jung, Melanie Klein, Donald Winnicott, Harry Stack Sullivan, Frieda Fromm-Reichmann, Ronnie Laing, Herbert Rosenfeld, Harold Searles and Gaetano Benedetti, amongst others. They all contributed to the psychodynamic understanding of schizophrenia and psychosis, and produced clinically useful material.

A number of treatments for the symptoms associated with schizophrenia have been reviewed in this section, highlighting the tension between different approaches. Such diversity of treatment options inevitably demands that a practitioner reconciles his or her

own view of the concept of schizophrenia, its causes, and his or her treatment approach in clinical practice.

Therapists' experience

to treat schizophrenic means to treat ourselves

(Siirala, 1983, p. 15)

Counselling psychology both values and promotes therapists' self-reflection, the use of self in therapy, and the appreciation of both subjective and intersubjective factors (BPS, 2006). From an intersubjective perspective it is valuable to explore the subjective experience of psychotherapists working with clients diagnosed with schizophrenia, and how working with this client group might impact on the therapist and the therapeutic process. Wilson and Lindy (1994) highlight the fact that the therapist's empathic ability can be strained by strong emotions elicited by client material. This suggests that it is important for therapists to reflect on the nature and dynamics of their interactions with the client, disentangling their own contribution from the client's. This also highlights the need to focus on therapists' subjective experiences, as opposed to focusing on forms of treatment and outcomes with this client group. This section reviews existing literature on therapists' experience of working with clients diagnosed with schizophrenia.

There is vast gulf between the way medicine explains psychiatric illness and the experiences of those who suffer. If therapists attempt to narrow this gulf they encounter a number of barriers. There are a number of potential problems arising from working with clients diagnosed with schizophrenia. A special risk with this client group is that therapy may potentially trigger or aggravate a relapse into psychosis. This can occur if symptoms are forcefully challenged, or if therapy proves to be so stressful that it results in a

significant increase in the client's level of arousal. Moreover, research suggests that there is an increased suicide risk among people diagnosed with schizophrenia; at least 5-13% of people diagnosed with schizophrenia die by suicide (Torrey, 2006). The APA (2013) cites other figures: 5%-6% die by suicide and about 20% attempt suicide on one or more occasions. Although the majority of people diagnosed with schizophrenia are not violent, some clients might pose a risk to the therapist (Gater & Gledhill, 2006). For all these reasons, working therapeutically with people diagnosed with schizophrenia might pose significant challenges for the therapist. This study aims to explore the challenges specific to this client group and understand how therapists deal with such challenges.

Prejudice against people diagnosed with schizophrenia is common, not only among the general public, but also amongst mental health practitioners, and is based on perceptions of danger and unpredictability (Thompson et al., 2002). Some studies show that mental health professionals prefer not to work with the severely mentally ill (Mirabi et al., 1985), and have negative attitudes towards the severely psychotic (Heresco-Levi et al., 1999). Service users in Australia reported more stigma experienced from mental health professionals than other groups of society (Walter, 1998). Read and Haslam (2004) summarise some factors that fuel prejudice:

> *... our need to deny our own fear of 'going crazy' and to project our 'madness' onto others. Causal beliefs that not only create the impression of a categorically separate group (thereby denying the dimensionality of emotional distress) but also exaggerate the difference between the two groups by proposing genetic aberrations are likely to fuel the reciprocal process of distancing, fear, projection and scapegoating*. (p. 141)

Benedetti (1987) writes about the fear which fuels social stigma towards people considered mad, and therapists' experience where interpretation "meets a nothingness into whose vacuum the therapist may feel himself being dragged. From this springs up fear of, and social aggression towards, psychotics" (p. 187). Levey and Howells (1995) propose that individuals with mental illnesses are commonly viewed as 'different', and that this perceived differentness may lead to fear, which is at the root of stigma. Karon (1992), however, notes that "what makes both professionals and the general public alike uncomfortable with schizophrenic people is not so much their difference from us, but their similarity" (p. 193). She suggests that the challenge presented by this client group can tell us more about the human condition. Therefore, by looking at the experiences of therapists working with people diagnosed with schizophrenia, this study hopes to gain a greater understanding of the relationship between the client and therapist and to diminish stigma about working with this client group.

Gelso and Hayes (2007) discuss the importance of therapists' subjectivity, their feelings, thoughts and bodily sensations (conceptualised as countertransference in psychoanalytic terms), and their impact on the relationship with the client. There are numerous definitions of countertransference. This concept has evolved as a result of the historical development of psychoanalytic theory. For the purposes of this research, countertransference will be defined as the therapist's total emotional response to the client, encompassing a wide range of conscious and unconscious reactions, which can be used therapeutically to help the therapist understand the client's unconscious emotions, defences and conflicts. In contrast to the original conception of countertransference – the analyst's unacceptable response to the client, reflecting the analyst's unresolved neurotic conflicts – it is currently seen as a natural and inevitable by-product of the therapeutic interaction (Jennings, 1987). A number of theorists acknowledge that the client's diagnosis affects the intensity of the

therapist's countertransference reactions (e.g. Giovacchini, 1972; Kernberg, 1965, 1970; Kohut, 1971; Winnicott, 1949).

Jennings (1987), in his paper 'Schizophrenia and therapist involvement: changing the practice of four major psychotherapies', argues that clinical work with clients diagnosed with schizophrenia has had a decisive impact on the theory and practice of psychoanalysis, and on existential, person-centred and family psychotherapies, stimulating modifications in standard technique that have encouraged a more active use of the therapist's own feelings. The traditional practice of psychoanalysis was challenged in the 1950s in light of Sullivan's interpersonal ideas, which, as Jennings argues, was of enormous influence on the theory, leading to revolutionary changes in the analyst's use of countertransferrential reactions. Sullivan's ideas were developed in reaction to Kraepelinian thinking, which largely dominated psychiatry at the time. Believing that schizophrenia was a fundamental disturbance in interpersonal relations led him to abandon the detached psychoanalytic stance in favour of personal involvement, active questioning and rigorous listening, where the analyst inevitably reacts emotionally to the patient (Jennings, 1987).

The therapist's experience working with clients diagnosed with schizophrenia has been known to include hate, narcissism, helplessness, avoidance and fear (Laufer, 2010). Winnicott (1949) writes that the analysis of 'psychotics' is seriously weighted by hate in countertransference, and that the analysis of a psychotic is inherently more 'irksome' than the analysis of a neurotic; and such analysis is impossible unless the therapist's own hate is "extremely well sorted-out and conscious" (p. 69). Therapists who work with this group of clients also mention feelings of ineffectualness, futility, disappointment and disillusionment (Laufer, 2010), and often express apprehensiveness about the meaning of their work with the severally mentally ill (Horowitz, 2008). Managing a therapist's

reactions that mirror the client's terror and bewilderment is often experienced as a battle. Kanwal (1997) writes about the inadequacy which streams out of the expectation that clients should get better, whereby promises of a cure can often intensify therapists' despair. Many therapists would agree that it is hard to show determination and perseverance in the absence of easily verifiable measures of change (Horowitz, 2002). Benedetti (1987) found that in working with clients diagnosed with schizophrenia an analyst can discover that which is most deeply repressed within him. Winnicott (1949) noted that the unresolved, primitive conflicts in the analyst, which are activated by the work with these clients, can be brought to light. Lukoff points out that "We all have something to learn about our own psyches, our psychological roots, from the experiences of psychosis" (1985, p. 126).

Another common experience described in the literature is the therapist's absorbingly urgent need to 'cure' the client diagnosed with schizophrenia – "compulsion to rescue the suffering patient" (Searles, 1961, p. 528). Searles also talks about the therapist's difficulty in resisting a common desire to mould the client into the therapist's own image, or impose on the client the concept of normality and reality. Adapting to the unique qualities of clients diagnosed with schizophrenia can be challenging and frustrating for a therapist. Part of the difficulty may be due to the fact that clients diagnosed with schizophrenia are able to point directly to the failings of a therapist (Fromm-Reichmann, 1959; Horowitz, 2002; Silver, 1993; Sullivan, 1964). This may be due to certain interpersonal mechanisms, unfiltered access to unconscious operations and/or the unique social position of people diagnosed with schizophrenia (Laufer, 2010). Various psychoanalytic theories assert that individuals diagnosed with schizophrenia speak the language of the unconscious (Storr, 1973); Rosen (1946) notes that people with schizophrenia have a superior insight into the meaning of the unconscious. Furthermore, Carveth (2004) states that "The despairing

schizophrenic is in some ways more honest than we self-deceived and adjusted ones" (p. 422). Fromm-Reichmann (1959) suggests that people diagnosed with schizophrenia occupy a unique position from which they often hold up a mirror to the hypocritical aspects of society. She also states that an integral component of a relationship with a client diagnosed with schizophrenia is therapists discovering insight into their own process.

Harold Searles (1965), a leading authority on the intensive psychoanalytic treatment of chronic schizophrenia, invited psychotherapists to attend to their feelings and reactions when working with a client, emphasising the crucial role of countertransference in the therapy of schizophrenia. According to Knight (1965), "Dr. Searles learned in his work that all therapy, but probably especially modified psycho-analytic psychotherapy with schizophrenics, consists of deeply significant emotional experience in each of the two parties to the therapeutic relationship, and that progress toward a good outcome requires ruthlessly honest self-awareness on both sides" (p. 17). In his paper 'Phases of patient-therapist interaction in the psychotherapy of chronic schizophrenia' (1961), Searles skilfully captures his observations concerning his emotional response to what occurs in the therapeutic relationship at various phases in the long-term treatment of chronic schizophrenia. Searles stresses that the feeling-involvement in therapeutic work is a deep one, due to the length of treatment and intense transference on the part of the client diagnosed with schizophrenia, which evokes intense, complementary feeling responses in the therapist. The difficulty for the therapist is that he or she is feeling what the significant adults in the client's life felt, but also what the client felt. He writes:

> *The therapist … experiences most intimately, within himself, activated by the patient's transference, the very kind of intense and deeply conflictual feelings which were at work, however repressed, in those adults in the past, as well as*

> *experiencing, through the mechanisms of projection and introjections in the relationship between himself and the patient, the comparably intense and conflictual emotions which formed the seed-bed of psychosis in the child himself, years ago.* (p. 522)

Searles saw the etiological roots of schizophrenia in the failure to either establish the mother-infant symbiosis due to mother's deep ambivalence, or the failure to resolve this symbiosis into individuation of mother and infant. The child then fails to proceed through the normal developmental phases of symbiosis and subsequent individuation; thus, the core of his or her personality remains unformed, and the ego-fragmentation becomes a powerful unconscious defence against the awareness of ambivalence in others of him/herself (Searles, 1961). The therapeutic relationship is curative because it offers a corrective symbiotic experience (Mahler & Furer, 1960). Searles writes about progression through phases in the relationship with a client, pointing out a particularly challenging phase of ambivalent symbiosis. During this phase, the relationship with the client assumes an absorbing, unparalleled importance in the therapist's life, when the therapist becomes enmeshed in the client's ego fragmentation:

> *The therapist's own ego-boundaries are weakened … [and] regression towards symbiotic relatedness tends to occur in the therapist himself as an unconscious defence against the intense and deeply ambivalent feelings – of helplessness, fury, loathing, tenderness, grief, and so on – evoked by his relationship with the schizophrenic patient, long before that relationship has become strong enough and well-defined enough to permit his recognition of these feelings and any full-scale expression of them, towards the patient*. (Searles, 1961, p. 532)

This dissolution may mean that the therapist temporarily loses his or her ability to fully differentiate between fantasy and reality. Searles points out that strong negative feelings, such as rage, hatred and murderous feelings towards the client, often arise, and become extremely burdensome and guilt-provoking. It is very hard for a therapist to acknowledge his or her murderous feelings towards the client and realise that the client as a result is deathly afraid of him or her. Searles believed that such realisation weakens the therapist's feeling of control over his or her own rage. At the same time, the client is directing his/her hostility onto the therapist, and the therapist's ability to survive it determines the progression onto the next phase of relationship. He argues that, in order to become deeply a whole person, the client needs a chance "to identify with the therapist who survives the fullest intensity of this kind of attack to which the patient was exposed in childhood and from which he, the patient, had to flee into psychosis" (Hoedemaker, 1955, referenced in Searles, 1961, p. 536). Searles notes that therapists, however, are usually unaware that a state of symbiosis is developing, or has long been established, and that it is easier to see this happening in a colleague rather than in oneself. He further points out the dilemma that clients face: they both need and fear their therapist, a dynamic that pervades the therapeutic relationship, making the therapist's position very complex.

Rogers, Gendlin, Kiesler and Truax (1967) conducted a study on the therapeutic relationship with individuals diagnosed with schizophrenia and noted that the work was highly challenging for the therapists. Occasional highly rewarding moments of real sharing, of dramatic experiences of changes and of developments in freedom of expression were interspersed with long periods of waiting, of silence and of lack of change. Regardless of the therapist's technique, he or she repeatedly failed to reach the client's 'feeling life' (p. 372). The clients' persistent silence and rejection of the therapists, they noted, were common experiences. The characteristics of this client group led therapists to

transcend the old techniques and to employ therapists' own concretely felt experience as a source of response to the clients. This finding, yet again, points out the crucial role of countertransference, particularly when faced with difficulties of reaching clients, such as through persistent silence. The authors concluded that clients diagnosed with schizophrenia were resistant to the therapy process and often rejected the therapist; they did not have a sense of the exploration process (p. 372). However, this can be partially explained by the participant selection process. The research group did not select clients who were willing or motivated to engage in therapy, or who were recommended by hospital staff as candidates for therapy; instead, they chose them according to strict research criteria, such as age, sex, social class, length of hospitalisation and lack of frequent ECT treatments. Thus, not surprisingly, therapy imposed on clients was met with resistance. Rogers et al. (1967) point out that the patient's silence was one of the most difficult obstacles for therapists to deal with. Gendlin (1966), writing about this same research project and his experience of silence, noted that this is a kind of silence where the client is cut off, where little is happening and where the relationship is either not established or has reached a clear impasse. He describes his experience of such long periods of silence:

> *I can be very frustrated, I can be very concerned to do something with him, and I can feel very badly that I do not know what to do. I can be very curious, personally interested. I can get quite angry because so much of my own welcoming for this patient is wasted. He is not getting any of it. He has no sense of my waiting for him. All of this makes a very rich 'stew'.* (p. 9)

Thus, Gendlin highlights the intensity of his experience, not knowing what to do and feeling frustrated as a result of his inability to reach the client.

Fromm-Reichmann (1952) describes the work with people diagnosed with schizophrenia and psychosis as much more taxing than therapy with 'neurotics' (p. 92). She notes some common difficulties that therapists encounter in this field of work, including fear, anxiety and difficulty in handling client's negativism in all its manifold manifestations. She warns that responding to fear with defensiveness and argumentation and to anxiety by placating the client, and treating the client's negativism as stubbornness, means the treatment is doomed to failure.

Horowitz (2006), in his paper 'Memory and meaning in the psychotherapy of the long-term mentally ill', points out that the breakdown of memory, and consequent difficulties in the capacity to create meaning, are common difficulties that clients diagnosed with schizophrenia experience. Entering the client's world of devastating loss is a long and arduous journey for a psychotherapist working long-term with clients diagnosed with severe mental illness. He writes: "The odd sensation that time is standing still and that change may happen in the tiniest of increments, if at all, leaves no therapist unaffected" (p. 183). This inevitably has an impact on the therapist: "no therapist immersed in work with the long-term mentally ill is spared the agonising search for a common thread in the swirl of chaos" (Horowitz, 2006, p. 177). He goes on to describe his own experience: "over the years ... I have struggled without letup to ward off feelings of ineffectualness and futility, fought against a spreading despair, and striven to seek order and coherence where both proved elusive" (p. 177). However, he suggests that this shared search serves as a binding element between the therapist and the client. He points to the never-ending battle of warding off the terror which in countertransference reflects clients' fear and bewilderment. The act of questioning the purpose of one's work, along with feelings of self-doubt, saturates the experience of work with the severely mentally ill (Horowitz, 2006).

Daniel Dorman, an American psychiatrist and psychoanalyst, refers to his experience of working with psychotic patients and his understanding of schizophrenia: “my approach has been to see schizophrenia as a state of profound developmental arrest. In fact I don’t see the schizophrenic as different from my healthier patients, at all but for degree” (Dorman & Penney, 1999, p. 17); “I made a decision that understanding schizophrenia was to understand the human condition” (p. 21). On being affected by his clients, of feeling affection towards and becoming attached to them, Dorman writes: “if the therapist is not in up to his waist he is not doing therapy” (p. 20), which suggests an intense relationship with the client that deeply affects the therapist in a number of ways. Moreover, he is stating the benefits for the therapist in such a relationship: “It’s learning, and if it’s authentic and done honestly with attention to the realities and trying to stay away from too much theory, one can learn and the learning will result in growth and development for both” (p. 22).

The above-mentioned literature suggests that therapists’ experience plays a crucial role in our understanding of schizophrenia. The concepts of transference and countertransference have been developed and are widely used within psychodynamic paradigms; they allow therapists to think about their own experience in a way that is helpful in their work with their clients. The above-mentioned literature on countertransference comes predominantly from the psychodynamic tradition. The cognitive behavioural approach, a recommended type of treatment for schizophrenia, does not on the whole work with unconscious processes, including therapists’ use of countertransference. Nonetheless, it seems that understanding and managing countertransference responses may be useful to cognitive therapists as part of reflective practice (Cartwright, 2011). Although not usually part of the obvious language of cognitive behavioural therapy, some cognitive practitioners have begun to view cognitions related to the therapist (or what psychodynamic practitioners call

countertransference) as an integral part of CBT, especially in working with 'difficult' patients (Prasko & Vyskocilova, 2010; Prasko et al., 2010).

Despite the rich clinical observations presented above, research on the clinician's experience of the therapeutic relationship with clients diagnosed with schizophrenia is scarce. Below, I review a few studies which have examined various aspects of the therapist's experience. Brody and Farber (1996) conducted a quantitative study, investigating, among other factors, the effects of client diagnosis on therapists' countertransference. They looked at three diagnostic groups: depression, borderline and schizophrenia. The authors reported the following results: therapists perceived that working with 'schizophrenic' clients was most challenging and evoked the least boredom among these groups of clients, but that it also evoked the most anxiety, frustration and hopelessness. Participants were also more likely to think about clients diagnosed with schizophrenia in their leisure time. Working with this client group was associated with a complex mix of countertransference reactions, and was accompanied by the temptation to give advice and refer clients elsewhere. The authors also noted that, compared to the borderline clients, some more negatively toned reactions, including annoyance and anger, were absent, whereas compassion for the schizophrenia diagnosis group was evoked much more than by the work with borderline clients. The results of this study need to be interpreted with caution, however, because the authors relied on therapists' reactions to vignettes rather than actual clients in actual clinical settings. Moreover, the questionnaires used in the study were created for the study itself, thus the measures of construct and predictive validity were absent. The questionnaires measured consciously acknowledged emotional reactions to imaginary situations, which, arguably, do not fully constitute countertransference, as they do not tap into unconscious conflicts and dynamics. Finally, the study looked at psychodynamically and psychoanalytically oriented practitioners only.

Laufer (2010) conducted a study which drew on phenomenological interview data collected from five psychoanalytic clinicians living in the United States, who were asked detailed questions about a therapeutic relationship with a client diagnosed with schizophrenia in which they experienced positive countertransference. Although aware of the hardships of schizophrenia, Laufer was interested in recovering what could be understood as valuable experiences of the individual diagnosed with schizophrenia, and therefore focused on the integrative or transformative properties of such an experience for the clinician. Her central research question was: "Please tell me about a time you have felt a positive or integrative experience as a result of a therapeutic relationship with a schizophrenic client". She proposed that an analyst might find insight into himself or herself while in a therapeutic relationship with a client diagnosed with schizophrenia. Laufer reported the emergence of two core categories: transformational and learning experiences. One way in which a person diagnosed with schizophrenia impacted on his therapist was by prompting a transformative experience in which the therapist went through personal change. The second way was by prompting an experience in which the therapist gained knowledge. Most of Laufer's participants highlighted that working with people diagnosed with schizophrenia taught them something about the human condition; Laufer suggests that "It reveals our vulnerability, our dependency on each other, and that's very threatening for people. They're just a reminder of how fragile we all are, and that's scary for people" (p. 170). Laufer concludes that the existence of the 'schizophrenic' reveals something to therapists they hadn't previously known: "that life makes sense, what it means to fear death, fallibility, humility, and what is important" (p. 170). Laufer's study was different from the current research in a number of ways: its exploration focused exclusively on the beneficial aspects of the work for the practitioner; the research questioning therapists' experience was narrowed down to the experience of positive

countertransference, as opposed to the totality of therapists' experience; and the sample consisted of psychoanalysts and psychoanalytic psychotherapists all living in the United States.

Larsson, Loewenthal and Brooks (2012) conducted a critical, discursive account of counselling psychologists' discussions about the diagnosis of schizophrenia. The authors noted that diagnosis of schizophrenia does not feature prominently in counselling psychology literature, and that there is a lack of empirical research pertaining to how counselling psychologists construct this diagnosis, and a lack of accounts of their experiences of working with this client group. A version of discourse analysis known as 'critical discursive psychology' was used to analyse semi-structured interviews with eight counselling psychologists talking about the diagnosis of schizophrenia. The authors concluded that, although counselling psychologists construct their experiences of working with individuals diagnosed with schizophrenia in a 'relational' way, the dangers of using language that pathologises is nonetheless always present. This paper highlights the fact that counselling psychology has been traditionally underrepresented in working with this client group.

On reviewing the existing but limited research, it seems imperative to investigate further therapists' subjective experiences of working with clients diagnosed with schizophrenia, and so contribute to the discourse on schizophrenia within the field of counselling psychology.

Research question

The research question was developed based on my personal and professional interest while working as a trainee counselling psychologist with two clients experiencing

symptoms of schizophrenia. In my training there seemed to be a lack of providing skills for counselling psychologists in working with clients diagnosed with schizophrenia. In assessment of client presentations of schizophrenia, and of the nature of working with such presentations, psychosis and/or psychotic experiences were not even mentioned in my four years of training. This led me to think that this client group was marginalised and even ignored by counselling psychologists, both in training and, as a consequence, in practice. I felt that, if counselling psychologists do not work with the 'severely' mentally ill, it reduces our profession to being merely a support service for 'minor' problems, thus impacting on the reputation of the profession. Additional training on this subject would allow counselling psychologists to participate in the multidisciplinary team discussions with confidence (for example understanding the impact of mediation on the process of talking therapy), thus leading to more respect form other professionals. Wanting to compensate for my lack of formal training, and to expand my knowledge in this area, I chose to research therapists' experiences with clients diagnosed with schizophrenia. Finally, in numerous conversations with both my colleagues and friends I felt a general sense of avoidance, suspicion and not wanting to know anything about 'madness'. This aversion further ignited my fascination and desire to know more about schizophrenia and therapeutic work with this client group.

As noted above the existing clinical literature highlights the importance of therapists' reactions and the impact that this client group can have on the therapist (Horowitz, 2008). Given that the research on therapists' experience is limited, and, given my personal curiosity with the topic, the following research question was developed: 'How counselling psychologists and psychotherapists experience working with clients diagnosed with schizophrenia'. The objective of the current study is to examine how counselling psychologists and psychotherapists feel about, what they think of, and how they otherwise

experience the therapeutic work with clients diagnosed with schizophrenia, as opposed to other clients.

As a profession, counselling psychology should not neglect any client group. Thus, this study aims to bring attention onto psychotherapeutic work with this client group, and explore potential challenges and rewards of it, and clinicians' views on the usefulness of psychotherapy in the current biomedically dominated world. It is hoped that counselling psychologists will be encouraged to work in this field. It also aims to identify what might be done in order to support therapists' work with this client group. It is expected that the study will help to better understand how the diagnosis has an impact on therapists' work. It is also aimed at reducing the stigma associated with those diagnosed with this serious mental illness. Finally, it is hoped that understanding clinicians' subjective experience of working with this client group may help other clinicians to better understand psychotherapy, schizophrenia and the personal implications of working with this client group.

Conclusion

In this chapter I have reviewed the literature on the historical understanding of schizophrenia, the diagnostic criteria, the current biomedical paradigm, psychosocial research and the literature on various aspects of working therapeutically with clients diagnosed with schizophrenia. The aim of this chapter has been to demonstrate to the reader that the biomedical model is currently the predominant model of understanding and treating schizophrenia. This biological determinism dictates that medication is the logical treatment of choice. On the whole, counselling psychologists do not receive formal training on working with this client group, and as a result rarely work with clients

diagnosed with schizophrenia. Therefore, the vast majority of counselling psychologists are not contributing to the debate on psychosocial causes of schizophrenia and the effectiveness of psychotherapeutic treatments. There is some evidence that the therapeutic relationship predicts outcomes of complex psychiatric treatment programmes in patients diagnosed with psychosis (Priebe et. al., 2011). It is therefore important to understand what difficulties therapists might encounter in establishing therapeutic relationships with this client group, and so help them manage such difficulties. Given the reported demands this client group makes on the therapist, the primary aim of this study is to look at the subjective experience of being in contact with, and trying to relate to, someone diagnosed with schizophrenia.

RESEARCH METHODOLOGY

This section presents the philosophical underpinnings of the qualitative methodology and the chosen method for exploring how psychotherapists and counselling psychologists experience working with clients diagnosed with schizophrenia. Qualitative methodology is discussed within the context of counselling psychology. The rationale for selecting IPA as the research method is outlined. Finally, the reflectivity, validity and quality of research are addressed.

Choice of methodology and method

The *Professional Practice Guidelines for the Division of Counselling Psychology* state that "it is expected that there will be congruence between the model of research chosen and the values expressed in counselling psychology. Research will be designed and conducted in the spirit of the ways of working emphasised in counselling psychology" (BPS, n.d.). Qualitative research, unlike quantitative, which is researcher driven and allows for little participant autonomy, generates in-depth, personal accounts of life experience which help to uncover varied aspects of the issue in question. Creswell (1998) argues that qualitative research is particularly appropriate for answering questions of 'How?' and 'What?' as opposed to 'Why?' Qualitative methodologies can be used to explore variables that are not easily identifiable (Morrow, 2007); they are designed to study the "experiential life of people" (Polkinghorne, 2005, p. 138); and they are useful for understanding the meanings people make of their experiences as well as examining the processes of meaning-making. As such, qualitative methods are ideal for in-depth explorations of the psychotherapy process (Hill, 2005; Hill, Thompson & Williams, 1997). They are seen as compatible with the principles of counselling psychology (Hoyt & Bhati,

2007), and counselling psychologists often find qualitative approaches more congruent with their therapeutic work (Morrow, 2007).

Morrow (2007) argues that it is the nature of the research question which should guide one's choice of research design. The rationale for the current investigation was to provide an in-depth, therapists' perspective of particular issues inherent in working with clients diagnosed with schizophrenia. Therefore, a qualitative approach was considered more appropriate, due to its exploratory nature, than a hypothesis-testing method; qualitative research emphasises meaning, understanding and interpreting rather than measuring, explaining and predicting (Smith, 2007; Smith, 2008). Furthermore, qualitative research assumes that there is no unitary reality apart from our perceptions, whereas quantitative research claims objectivity (Smith & Osborn, 2008). Hence, because the experience of working with a client is subjective, a qualitative research approach was chosen. Moreover, the aim was not to create a representative study, but to understand the manner in which a particular client group has an impact on the practitioner. For this reason a qualitative approach was thought to be more appropriate.

The primary reason for choosing IPA over any other qualitative approach was due to its congruency with the epistemological position of the research question. The aims set by IPA researchers tend to focus upon people's experiences and/or understanding of particular phenomena. It was thought that IPA would best be able to address the aim of the present study: to explore participants' experience. IPA involves "detailed examination of the participant's lived experience and is concerned with the individual personal account of an object or event as opposed to an attempt to produce an objective statement of the object or event itself" (Smith & Osborn, 2008, p. 53).

Other qualitative methodologies were considered during the process of developing the research proposal, including Grounded Theory and Discourse Analysis. Grounded Theory was not chosen because it is concerned with explaining factors that account for behaviour, and aims to develop a theory derived from data (Payne, 2007), whereas this study focuses on understanding and interpreting a phenomenon rather than constructing a theory about this topic. Unlike IPA, Grounded Theory employs a theoretical sampling technique whereby the identification and recruitment of participants is ongoing and is a result of emerging categories and theories (Glaser & Strauss, 1967). This approach was deemed inappropriate logistically due to the difficulty in recruiting sufficient numbers of participants.

Discourse analysis regards discourse as behaviour in its own right, and focuses on the context in which the discourse takes place (Potter, 2003). Potter and Wetherall (1987) posit that discourse analysis radically critiques the nature of 'reality' and problematises the concepts of personal beliefs and experiences and the link between personal experiences and action. Discourse analysis was not chosen because, although understanding the concept of language and how people interact with others about particular topics was important, it was not the main interest of this study. IPA, on the other hand, focuses on understanding personal experiences, beliefs and thoughts on a certain topic. Although a person's thoughts and beliefs are not transparently available through interview transcripts, Smith, Jarman and Osborn (1999) argue that the analytic process provides a framework enabling the thoughts and their meanings to be linked to action. Therefore, it was concluded that IPA was the optimum method for this research.

Theoretical underpinnings of IPA

As a distinct research method in psychology, introduced by Smith in 1996, IPA was first used in the mid-1990s (Smith, 1996). IPA has its theoretical foundations in phenomenology, which highlights the importance of individual perception, and in symbolic interactionism, which emphasises the importance of individual interpretation and construction of meaning. Ideography, phenomenology and hermeneutics had a major influence on IPA (Smith, Flowers & Larkin, 2009). IPA derives its ideas from Husserl's phenomenology on how to examine and comprehend lived experience (Shinebourne, 2011). Husserl emphasised a focus on the 'psychic life' through reflection, which allows us to grasp subjective experiences as they appear to us (Husserl, 1913, quoted in Smith et al., 2009, pp. 12-13). IPA is also influenced by the existential perspectives of Heidegger, who viewed phenomenological enquiry as an interpretative process. Phenomenology was originally developed to analyse the essence of experience. IPA places a strong emphasis on hermeneutics: thus, the interpretation of the analytic process, and of human meaning-making in general, is a fundamental aspect of IPA. IPA aims for interpretation to be both descriptive and empathic, and also critical and questioning. Therefore, analysis starts with an empathic summary of the participant's feelings, and then develops into a more abstracted and conceptual interpretation of the participant's words – a combination of a hermeneutic of empathy with a hermeneutic of questioning (Shinebourne, 2011). There can be multiple possibilities in interpreting the same text, such as "providing an insight into the participant's life world, offering an interpretation provided by the participant, an expression of the participant's unconscious conflicts and desires, or an account of a unique social interaction between two people in the interview situation" (Larkin et al., 2006, in Shinebourne, 2011, p. 22); each of those possibilities can be explored using IPA, as long as the focus remains on the participant's experience.

IPA recognises the role of the researcher in the meaning-making of the participant's experience. Smith (2004) refers to 'double hermeneutics': "the participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world" (p. 40). Therefore, the researcher accesses the world of the participant through his or her own preconceptions, and has to critically evaluate the influence of such preconceptions on the research process, because they may present an obstacle to interpretation (Smith, 2007). Heidegger refers to these preconceptions as "fore-having, fore-sight, and fore-conceptions" (Heidegger, 1962, p. 195).

In his review of Smith et al. (2009), Hammond (2010) argues that the combination of philosophical hermeneutics and phenomenology can be controversial, because phenomenology involves removing the interpreter from the analysis, whereas philosophical hermeneutics involves the opposite – immersing the interpreter within the analysis. However, he acknowledges that the founders of philosophical hermeneutics, Martin Heidegger and Hans-Georg Gadamer, practiced a 'hermeneutic phenomenology' (Smith et al., 2009). Conversely, Smith et al. (2009) argue:

> *IPA requires a combination of phenomenological and hermeneutic insights. It is phenomenological in attempting to get as close as possible to the personal experience of the participant, but recognises that this inevitably becomes an interpretative endeavour for both participant and researcher. Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen*. (p. 37)

IPA is concerned with the subjective experience of psychological phenomena, as contextualised in the wider world of meaning-making; it assumes a chain of connection

between people's talk and their thinking and emotional states (Smith, 2007). However, in IPA research it is acknowledged that this chain of connection is complex, and all inferences are therefore cautious; it recognises that the constructionist focus on language does demonstrate that alternative versions of stories are always possible. Therefore, an interview provides a contextual snapshot of an interactive account of the participant's experience (Larkin, Watts & Clifton, 2006). "IPA gives a central place to experience while acknowledging the multiple influences on it; its historical and cultural situatedness including language and social norms and practices" (Eatough & Smith, 2006, p. 119).

Finally, this approach accepts the inevitability of the researcher's perspectives within the research process; thus, the researcher's assumptions, beliefs, personal experience, education and training will have an effect on the interpretation of the data. Therefore, the aim is essentially to gain a third-person perspective or an insider's perspective on the participant's world as reconstructed by the researcher (Smith, 2007). Smith et al. (2009) acknowledge that the researcher is unable to totally bracket his or her assumptions and preconceptions; however, the aim is to become aware of such assumptions and preconceptions and make them more explicit. For this reason, reflexivity is vital throughout the analytic process, and will be addressed later in this chapter and discussion.

This methodology can be seen as consistent with the philosophy of counselling psychology mirroring counselling psychology's focus on subjective experience (Strawbridge & Woolfe, 2010). Therefore, as the proposed research is an in-depth exploration of therapists' subjective experiences of working with clients diagnosed with schizophrenia, IPA was selected as an appropriate method to investigate this research question.

Reflexivity

The researcher's assumptions and presuppositions inevitably influence the interpretation of participants' narratives. Smith (1996, p. 264) writes: "Access is both dependent on, and complicated by, the researcher's own conceptions which are required in order to make sense of that other personal world through a process of interpretative activity". Smith acknowledges that one's preconceptions may change in the process of interpretation, and that bracketing off one's preconceptions is a process which can only be achieved partially (Smith et al., 2009). Given this, a brief, reflexive account of the researcher's role in this research is provided so that the reader can judge the degree to which the analysis and interpretations were influenced by the personal world-view of the researcher.

I am a trainee counselling psychologist trained in person-centred, psychodynamic and cognitive behavioural approaches, with three years of experience of working with clients one to one in both the voluntary sector and the IAPT service. I would describe my theoretical approach as pluralistic, with particular interest in psychoanalytic theory. I have had some clinical experience of working therapeutically with two clients experiencing symptoms of schizophrenia. As noted above (p. 41), my training did not address the nature of working with client presentations of schizophrenia, psychosis and/or psychotic experiences. As I wanted to compensate for my lack of formal training in this area and to expand my knowledge in it, I chose to research therapists' experiences with clients diagnosed with schizophrenia.

My assumptions about what it feels like to work therapeutically with this client group came partially from my limited clinical experience, and partially from living with a person diagnosed with paranoia. My personal experience was that 'madness' carries a degree of fear and is not necessary related to physical threat; it is more a fear of the unexplained, the

unknown, and is thus something to be avoided – a fear which in some respects is similar to the fear of death. In order to limit the influence of my own preconceptions on the interview process, and to understand my own bias, I underwent an interview conducted by a colleague who used my interview schedule. The results highlighted my expectation, derived from my personal and professional experiences, that this fear was an important feature of the experience. The process of this mock interview allowed me to recognise, and thus reduce, the possibility of imposing my experience upon the participants. Consequently, I amended the interview schedule to remove connotations of fear of either physical or psychological threat. It was hoped that this alteration would enable the participants to volunteer their experiences of working with clients diagnosed with schizophrenia, rather than impose my views of the experience on them. Being aware of this, I was also mindful of it during the interview process, and avoided prompts which could have imposed an expectation that fear was a salient element of the participants' experience.

Furthermore, a field journal was used throughout the process of preparing the interview schedule, the literature review, and the data collection and analysis, in order to enhance reflexivity (Finlay, 1998). This journal was useful in recording and becoming more aware of the assumptions, preconceptions and ideas which arose at different stages of the research process.

Validity and quality

This study employed a set of procedures produced by Yardley (2000) for assessing validity and quality in qualitative research. Her guidelines are based on four key dimensions: 1 – sensitivity to context; 2 – commitment and rigour; 3 – transparency and

coherence; and 4 – impact and importance. There follow explanations how these key dimensions of validity and quality were demonstrated in the current study.

Sensitivity to context can be established in a number of ways, such as by demonstrating "sensitivity to relevant theoretical literature, to the socio-cultural context of the study and to the participants involved in the study" (Shinebourne, 2011, p. 26). This research demonstrated sensitivity to context by carefully considering the method of choice to ensure its compatibility with the needs of the research question, and the rationale for the adoption of the research method. As choosing IPA implies a commitment to ideographic principles and a focus on recruiting participants from a particular context and with a particular lived experience, this study recruited participants who all had an experience of a particular phenomenon in a particular context (working therapeutically with clients diagnosed with schizophrenia). Sensitivity to context was also demonstrated during the interview process by engaging with research participants with sensitivity to their individual experiences. During further stages of the analytic process, sensitivity to context was established in the commitment to care and attention to detail in analysing data. Sensitivity to the raw material was demonstrated by grounding the analytic claims in participants' accounts (Smith et al., 2009), presenting a significant number of verbatim extracts from participants' monologues to support the interpretations being made. This allowed the reader to check the interpretations made by the researcher. Sensitivity to context was further demonstrated by offering interpretations "as possible readings grounded in participants' accounts" and "contextualizing the report in relevant existing literature" (Shinebourne, 2011, p. 26).

Smith et al. (2009) state that rigour "refers to the thoroughness of the study, for example in terms of the appropriateness of the sample to the question in hand, the quality of the

interview and the completeness of the analysis" (p. 181). Commitment and rigour were demonstrated by the thoroughness and completeness of the project preparation process and selection of participants, as well as by engagement with participants with sensitivity and respect, and by commitment to detailed and meticulous analysis. They can be further evidenced by the researcher's extended immersion in the subject area and her developing skills in the use of the research method. In addition to the extensive reading within the field of this research, I attended several conferences on subjects related to schizophrenia and psychosis; I also participated in an IPA group which provided me with feedback on my interview schedule and the process of conducting interviews. Smith et al. further argue that commitment and rigour can also be demonstrated in the researcher's engagement with participants during data collection. The application of inclusion and exclusion criteria indicated the efforts taken to ensure that participants were appropriately selected, and were treated fairly.

Transparency and coherence refers to the "clarity of the description of the stages in the research process" (Shinebourne, 2011, p. 26). This criterion was demonstrated by providing specific details of the process of selecting participants, constructing the interview schedule, and conducting the interviews and the stages in the analysis. It was also aimed to achieve coherence by presenting the data, analysis and arguments, with all their contradictions and ambiguities, in a coherent way. Smith et al. (2009) point out that the reader is "trying to make sense of the researcher making sense of the participant making sense of X" (p. 41) – this inherent complexity was also sought to be presented in a coherent way. An audit trail evidencing the analysis is included in the appendices along with all transcribed interviews, initial comments and emerging themes; a list of themes for all interviews; and a list of final master and sub-themes. A field journal was kept

throughout the research process to help the quality of the analysis. Regular supervision and peer supervision were used to enhance the clarity of the argument within the thesis.

Impact and importance criteria are thought to be decisive in judging the value of a piece of research (Yardley, 2000). Yardley argues that "there are many varieties of usefulness, and the ultimate value of a piece of research can only be assessed in relation to the objectives of the analysis, the applications it was intended for, and the community for whom the findings were deemed relevant" (p. 223). Smith et al. (2009) suggest conducting an independent audit to ensure the validity of an IPA study. This suggestion was followed in this research as compliant with university procedure, meaning that all stages of the research were closely supervised by the Research Supervisor and the Director of Studies. Furthermore, the findings were discussed in the context of the existing literature on working with clients diagnosed with schizophrenia, and the clinical implications for counselling psychology.

METHOD

This section reviews the process of conducting the study, and provides a description of how the data were collected and analysed. It concludes with an outline of ethical considerations.

Participants

Because IPA is an idiographic approach, concerned with understanding particular phenomena in particular contexts, IPA studies are conducted on small, sufficiently homogeneous samples. The sample size in this case was guided by Smith et al. (2009), who recommend conducting between four and ten interviews for a doctoral research

project. Smith (2007) cautions that it is more problematic to meet IPA's commitments with a sample that is too large than it is to use one that is too small. This is also consistent with recent IPA investigations that used the IPA method for data analysis, recruiting on average 5-7 participants. To give a few examples, Perry, Taylor and Shaw (2007) recruited five participants to investigate the personal experiences of participants following a recent first episode of psychosis; similarly, Rizq (2012) interviewed five primary care counsellors, exploring their experiences of working with a borderline client. Lavie and Willig (2005) interviewed six women to explore their experiences of inorgasmia. The same number was used by Knight, Wykes and Hayward (2003) in their investigation of stigma in schizophrenia. Similarly, Whittemore (2007), in his study on the experience of schizophrenia, interviewed six individuals diagnosed with schizophrenia. Another study recruited seven participants for semi-structured interviews investigating perceptions of familial hypercholesterolaemia (Senior, Smith, Michie & Marteau, 2002). As a result, six-seven was deemed the target number of participants to be recruited for this study.

Participants were selected on the basis that they could grant access to the particular perspective on the phenomena under study. In order to ensure homogeneity within the sample, the following selection criterion was employed: participants should have worked therapeutically with at least one client diagnosed with schizophrenia. A number of potential participants expressed interest in the study who had not worked with clients diagnosed with schizophrenia, but had worked with clients reporting occasional psychotic experiences such as hallucinations following recent bereavement. Those participants were not interviewed, in order to increase the homogeneity of the sample.

The participants were recruited by searching two online directories listing any chartered counselling psychologists and accredited psychotherapists who advertised themselves as working therapeutically with psychosis or/and schizophrenia:

(1) Counselling Directory http://www.counselling-directory.org.uk

(2) Directory of Chartered Psychologists on BPS website http://www.bps.org.uk/bpslegacy/dcp

An email was sent to all potential participants who made their email address public. The email was brief, contained the research title and participation requirements and outlined the interview procedure. Participants who responded with interest were then sent, by email, the Participant Information Form (see Appendix 1 – Participant facing materials), which contained further details on the interview process and confidentiality, the research question, the right to withdraw, and contact details. Interviews were arranged at a time and place convenient for each participant.

Seven participants took part in the research. Participant number 1 was interviewed, and her interview was transcribed and analysed. However, during the interview it became apparent that her experience was limited to working with individuals diagnosed with schizophrenia as a support worker outside the UK. Later, she had trained as a psychotherapist, but had never worked with the target client group in this capacity. The social differences and the context in which she had worked were deemed too dissimilar from the rest of the sample. To ensure as great a homogeneity as possible, this transcript was removed from the sample and treated as a pilot. The interview process, transcription and analysis were nevertheless still used for training purposes to enhance my skills in interviewing and applying the IPA method to data analysis.

Thus, after the pilot interview was excluded from the sample, the data for the analysis were derived from interviews with six practitioners who had experience of working therapeutically with at least one client diagnosed with schizophrenia. All participants were accredited psychotherapists or counselling psychologists; they were all white; five of them were British and one German; three were male and three female; and they were all aged between 32 and 65. In total, the participants were recruited from their private practices, private mental health hospitals or therapeutic community organisations. All participants resided in London, UK. In order to preserve the anonymity of the participants, their names were changed into pseudonyms, and only their pseudonyms were/are used throughout the research. The demographics for each of the six participants are outlined in the table below.

Table 1: Participant Information

Participant	Gender	Nationality	Qualification	Modality	Years of experience	Current work setting
Ryan	Male	British	Psychotherapist, UK	Psychoanalytic	15+	Therapeutic community
David	Male	British	PsychD in psychotherapy, UK	Integrative	15+	Private practice
Evelyn	Female	British	Psychotherapist, UK	Integrative	15+	Private practice
James	Male	German	Psychotherapist, Germany	CBT	10+	Private hospital
Emma	Female	American	Psychotherapist, UK	Existential	10+ *	Private practice
Melanie	Female	British	Counselling psychologist	Integrative	5+ **	Private practice

* only 1 client diagnosed with schizophrenia

** 3 clients diagnosed with schizophrenia

Procedure

Before approaching the participants, ethical approval was sought from the Ethics Committee of the University of Roehampton. This project was approved under the procedures of the above mentioned Ethics Committee, which raised no objections on ethical grounds. Participants were informed that the study was investigating the experiences of working with schizophrenia. No deception was involved. During the interview, the participants were asked to read and sign the Participant Consent Form (see Appendix 1 – Participant facing materials), and by doing so they agreed to take part in this study. The research was conducted in line with the British Psychological Society's code of Ethics and Conduct (2009) and the Code of Human Research Ethics (2010).

All participants were made aware that their participation was completely voluntary, that at any point they had the right to withdraw from the interview without giving an explanation and that they had the right to refuse to answer certain questions. The researcher explained to the participants that they could stop at any time to ask any questions they might have. Participants were then told about anonymity, and that their names would be changed into a pseudonym so that only the researcher would know their personal identity.

Participants were advised while discussing client material not to disclose anything to threaten the anonymity of their clients. When, during interviews, any participant mentioned any information which could potentially identify his or her client, the researcher reminded them to avoid such details. Participants were also reminded that, if they felt uncomfortable with any part of the study, then after the interview they still had the right to withdraw their data from the sample. Contact details of the investigator, the Director of Studies and the Head of Department were given to each participant in case they had any concerns about any aspect of their participation, or any other queries.

Participants were given time to ask any questions they had. An audio recorder was then switched on and covered by a sheet to minimise disturbance. Following this, all participants had an in-depth, semi-structured interview with the researcher on their experience of working with clients diagnosed with schizophrenia. All interviews were audio recorded and lasted around 60 minutes each. Questions were kept deliberately open, with a minimum amount of interruption by the interviewer, to enable the interviewee to discuss issues of concern or interest to themselves.

Once the interview was finished, the participants were offered time to discuss any concerns or questions regarding the study. Finally, all participants were debriefed by the researcher verbally and were then given a printed out debrief form (see Appendix 1 – Participant facing materials).

All interview tapes were transcribed verbatim. The recordings were kept in a safe place at the researcher's home, and no information that could identify the participants was kept with the recordings. Any names or locations mentioned by the participants during the interview were omitted from the transcripts, to ensure anonymity. All participants were informed that they could obtain a copy of the completed research if they wanted to.

Materials

IPA aims to design data-collection events which elicit detailed stories, thoughts and feelings from the participant. A semi-structured interview schedule was designed incorporating guidelines suggested by Smith and Osborn (2008) and Smith et al. (2009). This type of interview was chosen because it allowed for flexibility within the interview process, e.g. for adopting questions through engaging with participants' experiences. Therefore, questions were open and expansive, and the participants were encouraged to

talk at length. The questions were conversational in nature, and open-ended, serving as a guide for potential areas to cover.

A pilot interview with a peer was conducted to test the interview schedule, and feedback from the pilot interviewee was obtained regarding the process of the interview. The feedback was used to amend the interview schedule accordingly. The final interview schedule was then reviewed by the supervisors. The reader can see the initial interview schedule in Appendix 5.

By conducting a second pilot (the first participant was subsequently excluded from the sample because during the interview it became apparent that her experience did not comply with the inclusion criteria) I improved my interviewing technique by learning to intervene much less within the interviewee's narrative and avoid leading questions. The interview schedule was not amended after the second pilot interview.

The interviews started with the main question: "Can you tell me about your experience of working with clients diagnosed with schizophrenia?" Participants were invited to talk at length and provide details of their experience that they thought relevant. The additional questions were asked more towards the end of the interview when the participants had finished responding to the main question, and only if they had not answered them already. Question 2 was intended to elicit further detailed descriptions of the experience. Question 3 was introduced to elicit participants' reaction to a controversial term – 'madness'. Questions 4 and 5, on limitations and achievements in therapeutic work with this client group respectively, were expected to prompt participants' opinions on the efficacy of psychotherapy for schizophrenia. The interview was concluded with two general questions aimed at eliciting any other relevant information which could not have been predicted by the researcher. The interview schedule is presented in table 2 below.

Table 2: Interview Schedule

Main question

1) Can you tell me about your experience of working with clients diagnosed with schizophrenia?

Additional questions

2) Can you tell me about any experience you may have of clients hallucinating or experiencing psychotic symptoms in a session?
3) How do you understand 'madness'?

   Probe used:

   Where does your understanding come from? (Training, theoretical orientation, colleagues' and supervisor's influence, work setting)

4) What do you think you can achieve with this client group?
5) What do you see as your limitations in working with this client group?

Concluding questions

6) If you were to give advice to another practitioner on how to work with this client group, what would it be?
7) Is there anything else you thought I might ask and I did not?

The questions were used to guide the discussion; however, a non-directive approach was adopted to encourage participants to develop and elaborate their own narratives about their experiences. The following general prompts were used throughout the interview to lead discussion: "You mentioned … can you tell me more about that?" and "Can you give me an example?" A field journal was kept throughout the process of interviewing, to enhance

reflexivity (Finlay, 1998). Immediately following the interviews, written notes on the researcher's experience, observations on participants' non-verbal communications and further reflections were made in this journal.

Data analysis

IPA was conducted using in-depth interviews, which enabled participants to provide a full, rich account and allow the researcher considerable flexibility in probing interesting areas which emerged. Yardley's (2008) guidelines for quality in qualitative research were followed throughout the analytic process. Interviews were audio-recorded, transcribed verbatim and subjected to detailed qualitative analysis in an attempt to elicit the key experiential themes in each participant's narrative (Smith, 2008). Smith highlights the importance of gaining familiarity with the text to enhance the process of identifying meaning units. For this reason I completed all transcriptions myself rather than use a transcription company. While transcribing, any thoughts and impressions and emotional responses were noted in the field journal.

The data were analysed using Smith et al.'s (2009) guidelines for IPA. At the first stage the transcript was read several times, and the right-hand margin used to make notes of anything that appeared relevant to the research question and of interest, in the form of keywords, phrases or summations of data. Exploratory comments were marked using the following coding system: descriptive comments were recorded in normal text and linguistic comments in italics; these two types of comments indicated content and meaning respectively. Conceptual comments were underlined in the exploratory comments section; they were aimed at illuminating participants' overall understanding. Notable quotes within the transcripts, which I believed concisely captured the participants'

experience, were put in bold to remind me to use them for theme illustration in the analysis section.

The second stage involved returning to the transcript afresh and reading it through fully whilst listening to the interview tapes once again. The left-hand margin was used to transform initial notes and ideas into more specific themes or phrases which call upon psychological concepts and abstractions – higher level interpretations. The third stage consisted of further reducing the data by establishing connections between the preliminary themes and clustering the left-hand column themes into higher order 'superordinate' themes which conveyed the conceptual nature of the themes therein (see Appendix 2 – Preliminary list of emergent sub-themes for each participant). These themes were then checked against participants' words to ensure they were indeed grounded in participants' accounts. As Smith and Osborn (2008) argue, it is very important at this stage to check the researcher's own sense-making response against what is actually said by the participant. This procedure was repeated across all participants' transcripts. When moving on from one transcript to another the initial themes were kept in mind; however, the researcher remained sensitive to new information.

Once all transcripts were analysed individually, sub-themes and master themes were identified by clustering the themes emerging from all participants' narratives. The researcher selected all themes from the participants, developing a large visual chart to help identify clusters and develop master themes (see Appendix 3 – Table of all emergent themes). The development of master themes is an attempt to "capture the quality of participants' experiences" (Offord, Turner & Cooper, 2006, p. 379). Some of the themes which were not particularly strong throughout the majority of the transcripts were lost; some were merged with other themes. The similarities and differences between

participants were observed by comparing themes emerging from each participant's account (Smith, 2004). Key quotations from the transcripts were selected to illustrate each theme. To mark the frequency of occurrence of each sub-theme across participants' narratives another table was created (Appendix 4 – Table of theme prevalence and extract selection). Finally, themes were translated into a narrative account and were explained and illustrated to produce a description of the participants' overall experience.

Smith et al. (2009) offer criteria for determining the prevalence of a theme and the representativeness of sub-themes. They recommend that a sub-theme needs to be represented across a sufficient number of participant narratives. They suggest that a minimum of two participants are required to represent a theme in a study of six participants. Thus, a minimum of two extracts, and sometimes more, were selected to illustrate a theme.

IPA requires a combination of phenomenological and hermeneutic insights. It is phenomenological in attempting to get as close as possible to the personal experience of the participant, but this inevitably becomes an interpretative endeavour for both participant and researcher (Smith, 2008). Thus, interpretations were presented as possible readings, and more general claims were offered cautiously.

Conclusion

The Methodology and Method chapters endeavoured to make the research process as transparent as possible and allow the reader to assess the rigour of each stage of the research, starting with the rationale for selecting the research method before discussing issues of reflectivity, validity, ethics and quality of research, leading to the step by step description of the process of conducting the study and data analysis.

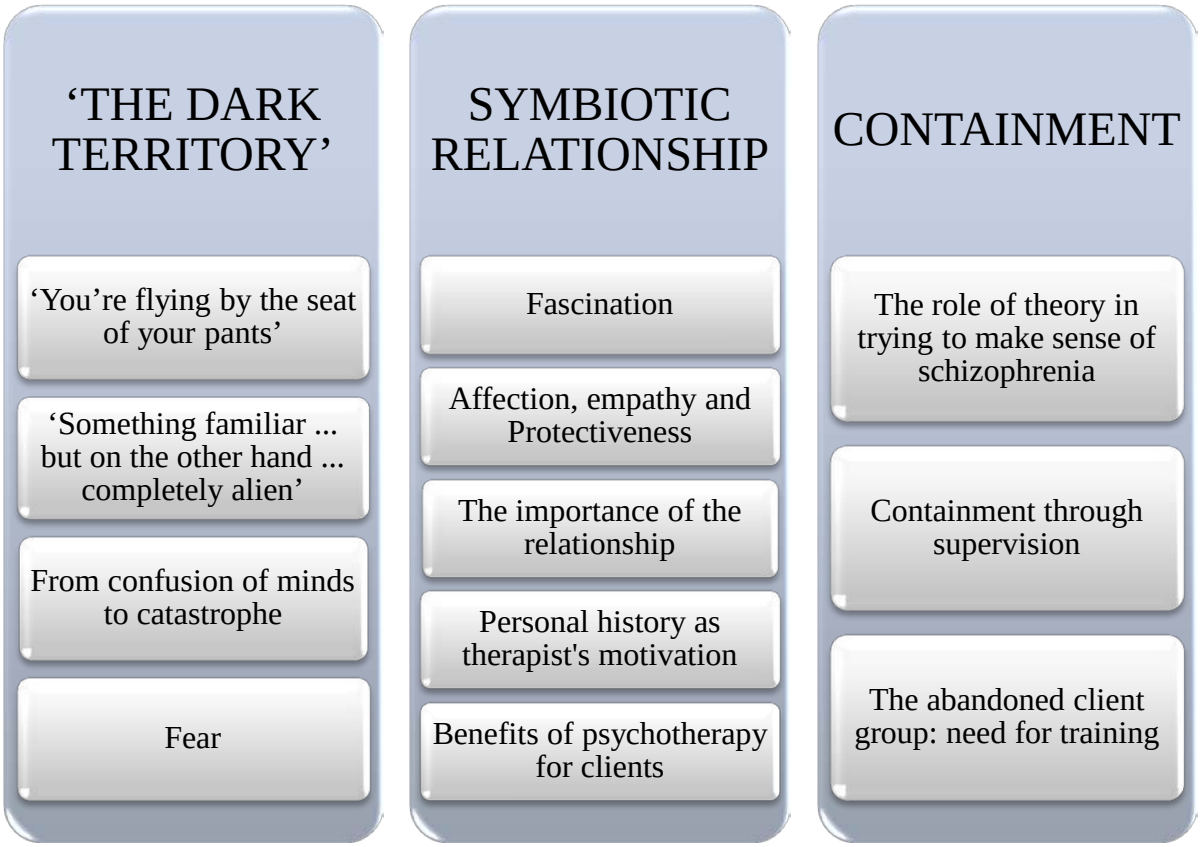
RESULTS

Overview

Interpretative phenomenological analysis of six interviews resulted in the identification of three master themes, with twelve sub-themes. These themes are explored in detail in this chapter. This analysis is one account of therapists' experiences of working with clients diagnosed with schizophrenia, and it is acknowledged that different researchers could have focused on different aspects of the participants' experiences. The themes identified in this analysis were selected based on their relevance to the research question; consequently, they might not cover every possible aspect of the participants' experience. The themes identified were common to most accounts; however, naturally, there were aspects of difference, divergence and disagreement. These differences will be explored throughout this section.

Each theme is presented with supporting verbatim extracts from participants' narratives in order to achieve transparency and to illustrate the themes (Elliott, Fischer & Rennie, 1999). Some minor amendments have been made for ease of reading. In quotations, material that has been omitted is indicated by ellipsis points '...'. Words inserted for clarity are represented in paired square brackets [ ], and description of non-verbal communication from participant are provided in paired parentheses ( ). The participant's pseudonym and the page number in brackets after each quotation is added to help the reader to find the quote in the participant's transcript in Appendix 6. All identifying information has been eliminated to ensure anonymity, as discussed in the Methodology and Method chapters above. The analysis resulted in 12 interrelated sub-themes grouped into 3 master themes. They are presented in the table below.

Table 3: Master themes and sub-themes



The master themes above emerged from the analytical process using Smith et al.'s (2009) guidelines for IPA. A step-by-step description of the analytic process was presented in the Method section above. In order to illustrate how this process was employed in this study, and to make the analytic process more transparent to the reader, I now present an extract from a transcript analysis showing the transformation of the original text into a theme and how the assimilation of such themes across participants' accounts result in the formation of master themes. The extract is taken from Ryan's interview and can be located on pages 1-3 of the transcript.

In the right hand column the initial exploratory comments are recorded. The first step involved the examination of semantic content and language use on a very exploratory level. Thus, anything of interest is noted here, whilst the researcher is still gaining

familiarity with the transcript and identifying the issues the participant is talking about. Thus, a comprehensive and detailed set of notes and comments on the data is produced incorporating descriptive, linguistic and conceptual comments.

Table 4: Extract of the analysed interview transcript

Emergent themes	Original transcript	Exploratory comments
Feeling lost – difficulty understanding Schizophrenia as an alien territory The role of theory Therapist as an outsider	… the subjective experience was very much one being lost, really, feeling that something, having the impression that something was familiar, you know, he was talking about the virgin and some catholic images, myths or ideas like that. So something familiar but on the other hand it had an obvious twist which made it completely alien and unfamiliar and seemed completely mad. Just to, difficult, you said free association, remembering now living in a house probably 20 years ago, moving to a house and the, there is a little garden and there's joined other garden either side and we got sort of on friendly terms with people on the other side and there was an elderly couple on one side and they were sort of born again Christians you know, Protestant and [inaudible] or something like that and they used to say things like you know if you started talking to me 'oh, I'm having difficult time at work' or, you know, whatever, they would say things like ,you know 'have a word with Jesus, you know, he will sort it out for you or something like that. As if it was something like you know pick up the phone and call God kind of thing and I used to say to [name of his wife], my wife, I used to say 'obviously they are really mad'. Ok, they weren't suffering from psychosis amm, but in relation, in comparison with the religious group I've been with they seemed pretty wacky and yet they obviously didn't have psychosis so am, you know, there was another sort of distinction coming in there for me in my mind, so when I am thinking about the chap with psychosis, it wasn't just that he had nutty religious beliefs which I could find with our neighbours in other words, beliefs bore no relation to my experience or, or, religious beliefs amm, it was something else, something different and that	*Is struggling for words* Normality/ordinariness versus "alienness" of schizophrenia The twisting of the familiar seems mad Gestalt/picture and background 'seeing it one second and not seeing it a moment later', similar to his description of seeing something as 'normal' and then not Compares somebody who is 'pretty wacky' with somebody with psychosis Unusual beliefs are insufficient for somebody to be defined as psychotic *Schizophrenia' and psychosis are used interchangeably* Feeling lost in an alien territory signifies for the participant that a person is psychotic <u>How does he understand this breakdown in</u>

	feeling of one being lost. So that's the first thing I'd say is the sense of being lost in an alien territory where there's some, something missing in the communication amm and you didn't want me to say anything about, I think, about theory, hmm, because I could talk to you why I think that is may not be so relevant, well, what I'd say is that, the nutty neighbours sound nutty because amm, their discourse is one which is specific to a group which I don't belong to, so they have a way of speaking and a way of thinking which is alien to me, I'm an outsider, it's a bit like foreign language. Whereas with the chap with psychosis it's not really a language because it's not shared, other, other people with psychosis don't agree with him …	<u>communication?</u> Explains how he makes a distinction between psychotic discourse and a non-psychotic one: psychotic discourse implies an individualised use of language where there is no agreement on terms shared by a community. Theory seems to help Ryan to deal with the experience of feeling lost.

The main focus of the above descriptive commentary (plain text in the right hand side column) is to describe content, which allows the recording of key words, phrases or explanations. At this stage the focus is on taking things at face value and capturing the objects that structure the participant's experience (i.e. 'Normality/ordinariness versus "alienness" of schizophrenia').

Linguistic comments (presented in italics) draw attention to the ways in which the participant conveys meaning and content, such as the use of pronouns, pauses, laughter, repetition, tone, degree of fluency, metaphor etc. For example, at the beginning of the extract Ryan is struggling to find words when describing feeling lost.

Finally, conceptual comments (underlined) take an interrogative form, reflecting on what the content presented by the participant means. Sometimes such questions may lead nowhere, whereas others may lead to work at a more abstract level. This level of interpretation draws significantly on the researcher's personal experience and professional knowledge. At this stage, however, the objective is not to pin down an understanding but rather to open up a range of provisional meanings.

During the second stage the left hand column is filled in. Emergent themes are developed aiming at reducing the volume of detail (the transcript and the exploratory comments) whilst mapping the connections and patterns. At this stage not only the transcript but the comments as well are taken into account. Themes are usually expressed as phrases reflecting the researcher's interpretation. For example, the emergent theme 'The role of theory' captures the initial exploratory notes related to how Ryan makes sense of his experience and what he founds helpful in his work-.

Once this process is completed for the whole transcript, all emergent themes are then listed in chronological order, and the next step involves a development of mapping the themes together. Here is an extract of the list of emergent themes which are clustered to form a super-ordinate theme, 'Empathy':

Empathy

1) *Compassion towards client's suffering or fear*
2) *Importance of establishing an emotional connection, allowing therapist to be affected by client's distress as a way of relating*
3) *Empathic response towards client's traumatic experiences*
4) *Self-harm in working with schizophrenia elicits empathy in the therapist whereas with non-psychotic clients it alienates the therapist*

The emergent themes are then compared and contrasted with the other participant transcripts. At this stage certain themes, such as number four, are excluded because they do not appear in any other accounts and are not strong enough to form a separate sub-theme. Theme two, on the importance of establishing emotional connection, is merged with other participants' themes to form the sub-theme 'The importance of the

relationship', which then becomes part of the master theme 'Symbiotic relationship'. A number of ways of clustering the data were considered to ensure that the "account produced is credible and justified in terms of the data collected" (Smith, 2003, p. 235).

It is acknowledged that the interpretative judgements made in the analysis are subjective. At the same time, the analysis performed was systematic and rigorous in its application, and the results of this analysis are available for the reader to check subsequently. Full analysed transcripts from all six participants are included in Appendix 6; tables with emergent themes are shown in Appendix 2 and 3; and the themes frequency table can be found in Appendix 4.

Below follows a detailed exploration of the three master themes with twelve constituent sub-themes.

MASTER THEME 1: 'THE DARK TERRITORY' – THE IMPACT OF CHAOS ON THE PRACTITIONER

The title of this first master theme, 'The dark territory', comes from David's interview (p. 15), where he uses this expression to describe the work with schizophrenia and psychosis, noting that people tend to shy away from 'madness'. This metaphor evokes associations with the unknown, possibly something evil or somewhere one might get lost. This master theme attempts to explore those 'dark' aspects of working with people diagnosed with schizophrenia by capturing the chaos, state of confusion, feelings of being lost and not knowing what to do, and feelings that one's senses are being affected and perceptions distorted, leading to a mixture of bewilderment, anxiety and fear that all participants described in one way or another. These had a sense of danger and psychological threat,

making the therapist's role challenging and complex. These aspects will be explored in the following sub-themes.

"You're flying by the seat of your pants"

Not knowing what to do and how to respond, being disoriented and lacking any sort of navigation tool were discussed by most participants. There was a sense of chaos and unpredictability. Participants often found themselves struggling to make sense of the situation; they felt unable to contain it and did not know how to respond. They described these experiences in the following quotes:

> *I had no clue what was going on (Evelyn, p. 11)*
>
> *I didn't feel physically threatened, I felt 'I am not quite sure what to do here' (Melanie, p. 5)*
>
> *the subjective experience was very much one being lost … in an alien territory where there's some, something missing in the communication (Ryan, pp. 2-3)*

Schizophrenia and psychosis are portrayed as alien by Ryan. This aspect will be explored below, in the next sub-theme. The not knowing how to respond is perceived as pressure to know, which potentially challenges the therapist's competence:

> *often one is completely lost and not … haven't got a clue what on earth they are talking about or how on earth to respond or what sense to make of it, trying to make some sense of it, perhaps wrongly … that, that whereas that element in the relationship with the person is thinking, you know it, you know all about them and you are making sense of it, whether that element, that element can be a kind of pressure which you have to be aware of that, that you feel under pressure to, to*

> *know what it's all about, to know what they are talking about and then … remind yourself that it's ok not to know, in fact better not to know (Ryan, p. 7)*

In this passage Ryan repeats a few times "how/what on earth", which suggests a lack of necessary competencies for dealing with this client's presentations or the despair that perhaps there is nothing one can do to really understand. The fear element comes in when he says "better not to know", suggesting that it is not only that there is nothing one can do to really understand, but perhaps that one does not want to fully understand, as it would mean losing one's mind. This aspect will be explored further in the sub-theme below (From confusion of minds to catastrophe) on the fear of losing one's mind. Ryan learned from experience to resist this kind of pressure and reassure himself that not knowing is in fact the nature of this type of work rather than a measure of one's competency. David supported this point, stating that one has to let go of the idea of oneself as omnipotent, all-knowing therapist:

> *one finds that people … have an overwhelming sense of being superego driven that they have to get it right, there must be a right way to work with such and such a person and of course … you're flying by the seat of your pants and that's the way it is and you need to take your authority but at the same time be humble before the client and follow your instinct much more than you normally would (David, p. 16)*

David acknowledged that there is no right or wrong; in the territory where the unconscious processes govern he is inviting therapists to follow the instinct and "stop being a hero" (David, p. 19).

Another element that Ryan highlighted is the unexpectedness and shock which intensifies this feeling lost and not knowing what to do:

> *it's always unexpected that they are coming to say, they say something unexpected and it throws you (Ryan, p. 9)*

David also talked about the unexpectedness, which has an almost supernatural, mystical feel to it:

> *it [the fear of losing one's sanity] can creep up on you, you think you are in charge but that's hubris, that's arrogance, you think you know what you are doing but suddenly you find they've got in at the back door and your balance has suddenly been undermined (David, p. 15)*

Not knowing how to respond may lead to therapists not 'getting' the client and being caught up in the concrete. Participants acknowledge this difficulty; for example, in the extract below Ryan talked about falling into all sorts of traps:

> *not knowing how to respond of course is a big, big thing; people come to you and say funny things; it's a, strange things or nonsensical things and often, one is sort of confronted with not having a clue how to respond and having a number of sort of set ways of responding that sort of slightly gets you out of the situation, gets them off your back somehow … but usually they are not very helpful ways to respond because they are kind of like automatic responses … I frequently fall into all sorts of traps or making a joke or responding in a wrong way (Ryan, pp.* 7-10*)*

In this sub-theme, participants' bewilderment and not knowing how to deal with the situation underlie the extreme nature of the work where therapists' abilities are repeatedly challenged, throwing them off balance. However, most of them seem to accept this aspect as an inevitable characteristic of the work, and have learnt not to be affected by their sense of incompetence. Thus, doubting one's competence did not feature in the accounts. It

seems that there is virtually nothing that can prepare a therapist for this work, and probably the most reliable tool one has in this field is one's intuition.

'Something familiar but on the other hand completely alien'

In this theme, a paradox of ordinariness and simultaneous 'alienness' of working with schizophrenia and psychosis has emerged. On the one hand, participants could not see "what the problem was" (Evelyn, p. 25), and experienced the work as any other work they did. On the other hand, there was a sense of something very different and alien. This also relates back to the theme just explored above; it is this 'alienness' of schizophrenia that leads to the therapists not knowing what to do.

Overall, participants saw their work with clients diagnosed with schizophrenia as similar to their ordinary work with clients, and they described dealing with the symptoms as they normally would with any other client presentations, taking it seriously and with respect. They repeatedly used words such as 'normal', 'ordinary' and 'same':

> *just treats it as a straight episode. That I think is the way to deal with it, just as we are doing our ordinary work as psychotherapists (David, p. 18)*

> *feels quite normal, just like a normal kind of session as it were. Obviously it is really interesting … it's slightly out of the ordinary, it's stimulating (Evelyn, p. 16)*

Evelyn went on to talk about how she works with clients' hallucinations:

> *it's just like a normal session in a way and it's just that the topic of conversation is about the experience of the hallucination (Evelyn, p. 13)*

and later on in the interview she highlighted the importance of empathy and strengthening of the therapeutic relationship, which again is part of the ordinary work of therapists:

> *to tune in with them empathically same as you would with anybody else to facilitate them being able to communicate to you, you know, genuinely (Evelyn, pp. 16-17)*

However, at the same time participants noted that something is different about working with this client group. Most of them struggled to describe it, which also relates back to the previous theme of feeling lost:

> *You are often working in utter, unbridled chaos (Evelyn, p. 28)*

> *And it can feel quite in alien experience I think (Melanie, p. 8)*

Melanie also viewed her reality as fundamentally different from her client's; thus, once again, highlighting the alienation of schizophrenia:

> *I think by having to realise that her reality was very different (Melanie, p. 7)*

Later, Melanie talked about how different and incomprehensible the experience of schizophrenia was to her:

> *I can get, perhaps, to a degree what it might feel for someone who has a panic attack, or to a degree what it might feel like to feel depressed or to struggle with an eating disorder, but can I do that with someone with schizophrenia? I think the answer is 'no' (Melanie, p. 16)*

Ryan highlighted the paradox, his sense of his work being ordinary, understandable and familiar and at the same time different and alien:

> *having the impression that something was … familiar but on the other hand it had an obvious twist which made it completely alien and unfamiliar and seemed completely mad (Ryan, pp. 1-2)*

Evelyn went on to describe this dual feeling of normal versus alien, presenting her experience on a continuum:

> *it's almost like as if there is a spectrum of being this type of work. Some examples where I, I am 100% or pretty much 100% grounded in reality … you've got the sort of real extremes of it where you just feel like you haven't got a clue what's going on, and then there are other examples where you sort of you are on a kind of slightly, you definitely not grounded and you haven't completely lost it but you're on a sort of different plane (Evelyn, p. 17)*

Emma talked about a shift in her perception of the client whilst her client was going through a psychotic episode:

> *there was a lot of anxiety in my reaction ... I think really an awareness that something really different was going on in the room and the difference was really the person (Emma, p. 8)*

> *then I started to observe something very different about the person that was sitting right in front of me and I was, it was early in my career, and first I was a bit, amm, I guess I felt I didn't know what to do observing this situation other than taking it to supervision and in our last two sessions the person that sat in front of me was quite different from the person who was sitting in front of me in session two (Emma, pp. 4-5)*

Emma highlighted the anxiety which she felt as a result of noticing a change between her usual perception of the client (from 'ordinary' work to 'different'). She could not explain what exactly she found different; but that difference in the person of the client paralysed her so that she did not know what to do. This also relates to the earlier theme on feeling lost and disoriented. Participants on the whole struggled to describe what that difference entails. This difficulty, of putting 'alienness' into words, relates closely to an earlier theme: of feeling lost and not knowing. This also links to the themes which will be discussed later, on how participants managed to contain the situation. It seems that training and theoretical knowledge, despite proving the grounding for the practitioner, do not fully sort out the chaos. Thus, the otherness, the subjective experience of the client, remains incomprehensible.

From confusion of minds to catastrophe

The most intense aspect of working with people with schizophrenia and psychosis is gathered in this sub-theme. Participants' experiences ranged from feeling spaced out and confused to utterly disoriented, and in danger of losing their minds. All these experiences, although varying in intensity, had an element of psychological threat, some sort of blending of the therapist's and client's minds where participants entered into a territory of high risk psychological danger. In participants' accounts psychosis acquires an almost contagious quality whereby psychotherapists' own psychotic layer becomes activated. None of the participants, however, described wanting to avoid these psychotic experiences.

In the following extracts Melanie talked about feeling spaced out, as well as her sense of unreality and disorientation:

I struggled initially with the thought processes, kind of separating out my own reality to what she was talking about, and there were moments where I felt a little bit disorientated to begin with (Melanie, p. 4)

Again, I got that very similar feeling almost being in a slight parallel universe that she was kind of talking but I wasn't; I felt quite spaced out (Melanie, p. 12)

I think it was to do with transference as, well, feeling sometimes just slightly spaced out, amm, and kind of not quite knowing where I was. I took that to be a little bit what she was experiencing, there was something very, almost unreal (Melanie, p. 8)

Here, Melanie was making sense of her sense of unreality in terms of psychoanalytic concepts of transference and countertransference, which relate to the theme of how participants strived to contain themselves in this emotionally challenging work, particularly by relying on theory. This aspect will be discussed later on in this chapter, in the master theme 'Containment'.

In the extracts below Evelyn captured the confusion of minds which happens in the therapy room when working with a client diagnosed with schizophrenia:

feel kind of attacked in my mind … feeling so confused (Evelyn, p. 8)

I was completely and utterly confused, I couldn't bring to bear any kind of, amm, or very little rational sort of thought process into what was going on … it was so sort of un-articulable at that point (Evelyn, p. 10)

I've chosen to tune in to what the person is experiencing and their mental state … but in doing that … I've got the sort of the energy of it in my mind (Evelyn, p. 8)

In the above extract Melanie talks about "separating out", and Evelyn repeatedly uses words such as "confusion", which evokes associations with alchemy, the co-mixing of the elements in such a way that the two original elements cannot be separated again. In the participants' accounts there is a sense of a similar process where the main elements are the therapist's and the client's minds. Thus, the merging of the minds and the difficulty of separating oneself out from it are expressed.

Evelyn went on to describe how this confusion of minds impacted on her cognitive processes and perception:

> *you feel like you lost grip of your sort of rational processes; it's like you can't think properly or you can't, you can't remember, if you try to remember what the person has just said you can't remember what they've just said, you can't remember whether there is a thread to what they've been saying, you can't remember what you said you can't think what to say next so it's a really, amm, confused and that, that can be an alarming experience … years ago I used to feel really kind of quite threatened by that and sort of have this sense of being in a bit sort of psychological danger like I might sort of lose, lose a grip now I don't, I don't feel like that (Evelyn, pp. 8-9)*

> *physically I feel quite sort of literally off the ground and psychologically I feel off the ground, so I feel like I am sort of floating … I have quite a lot of sensory sort of experiences which I suppose is getting into this, sort of this psychotic layers being stimulated a little bit … the thing I am most aware of as I think about it, it's colours being very bright, as well having sort of slightly distorted perceptions (Evelyn, p. 18)*

Evelyn also described what she terms ‘psychotic communication’ and different ways of communication with the clients, including dreams – something that David also mentioned later on.

> *there is something about working with psychotic clients where they communicate on a completely different level … really powerful level (Evelyn, pp. 5-6)*

> *a lot of psychotic people somehow, you know, communicate or how we communicate together is that something is said in words, some things, you know, happen in the room, and some things happen via, via dreams (Evelyn, p. 6)*

> *it’s pretty much only working with psychotic clients that I have this experience where I dream about them very, very vividly … I think what’s happening is that I am having psychotic processes (Evelyn, p. 2)*

In talking about psychological danger David talked about being impacted on by the client to the point of experiencing an extreme terror of losing his mind:

> *It’s a feeling of catastrophe, overwhelming catastrophe, and the, the fear of that degree of loss of control is so profound that we would do almost anything to prevent ourselves from feeling it. Now, I, I’ve learnt that what we do to protect ourselves is also part of the normal order of things (David, pp. 15-16)*

> *I think it’s because we are dealing with such primal stuff and our own terror of losing our ego and our sanity is so profound (David, p. 12)*

> *the pressure on anyone who hasn’t robustly done their work in managing their own reactions, amm, is immense, and sometimes extreme mistakes are made in this*

> *kind of work it is much more likely. And furthermore in this kind of work projective identifications are extremely powerful (David, p. 13)*

In this last passage David mentions psychoanalytic concepts, such as projective identification, which can be defined as an unconscious phantasy in which aspects of the self or an internal object are split off and attributed to an external object (Klein, 1946). Participants, being aware of the powerful unconscious process at play with this client group, also discussed ways of making sense of them and using the psychotic communication productively by attending to the therapist's own unconscious processes. David also supported Melanie's view on psychotic communication, making sense of it in terms of countertransference:

> *you also need to be very sensitive to your dreams, you need to be very sensitive to your own phantasies, you need to be very sensitive to your own moods; if you have moods of despair or great elation you should consider the possibility that this is in some way connected with your client and so on and so forth, it's powerful stuff (David, p. 16)*

It seems that the most intense descriptions were provided by the participants with most experience and who worked intensively with people with psychosis and schizophrenia (David and Melanie). David described his experience as losing control and losing his sanity – a feeling of overwhelming catastrophe. These powerful descriptions portray people with schizophrenia and psychosis as almost possessing lethal power. It is not something that they do to the therapist, but it is their mere presence that reminds the therapist of the fragility of his own sanity. These aspects will be explored further in the following discussion chapter.

Fear

This sub-theme is closely related to the previously discussed sub-theme. Fear featured in a number of participants' accounts. However, the participants felt afraid of rather different things, including fear of physical violence and/or verbal aggression for some, fear as a psychological threat ('mentally attacked') and losing one's sanity for others, and fear of not knowing what to do (which relates back to the previous sub-theme, which explored the psychological danger in more detail) for others. All those elements were present for practitioners at the beginning of their careers, but, as they gained experience, fear diminished and disappeared altogether for most.

For one participant, Ryan, fear was still a strong element of his experience of interacting with people with schizophrenia and psychosis. He highlighted the uncontained aggression, unpredictability and unexpectedness of his clients' behaviour:

> *Another strong element in the experience of interacting with people with psychosis is fear. Often I'd experienced the edge, a violent edge or an, amm, something uncontained, amm, the, there is a certain level of anxiety in which you, you, you have the sense that things could erupt, go over the top, explode, you know, if you respond in a wrong way will the person, you know, become aggressive or angry or violent or something like that or be just, just be upset or something, and that's been a very common feature I think (Ryan, p. 4)*

> *the fear element, the violence, the, the, it's not that violence is always there but you have a sense that you don't know what will trigger … what will come out somehow (Ryan, p. 5)*

To a lesser degree the fear was present in the accounts of other participants as well; however, it was associated with the very first experiences of working with this client presentation and fear was often a result of not knowing what to expect:

> *if I am honest, the initial meeting was a degree of fear ... fear of not, not knowing what to expect (Melanie, p. 3)*

Establishing an emotional connection with 'the human part' of the client seems crucial in overcoming the fear.

> *was I fearful of the clients that I worked with? Possibly initially, until I've got to know the human part (Melanie, p. 17)*

Similarly, Evelyn spoke about her first client diagnosed with schizophrenia. She entered the room not knowing that he had a psychiatric history and was floridly psychotic at the time of the session:

> *he was the first person I'd seen as a psychotherapist and I was completely terrified ... it was a real shock so that I didn't know that, you know I wasn't expecting that [the client was psychotic] I thought, I was reacting as if I thought he was going to attack me, although actually he'd not said anything or done anything to indicate that that was a possibility (Evelyn, p. 7)*

Here, Evelyn talks about being unprepared for seeing a client with this presentation. Moreover, she recalls that the client did not seem to pose any real threat, which suggests that it was Evelyn's overreaction fuelled by the unexpectedness and her lack of experience.

> *I never again had that experience of feeling I was going to be physically attacked, but I have had the experience, which is very rare, haven't happened in the last at least 7-8 years, let's say, but for a while I used to feel kind of attacked in my mind ... feeling so confused (Evelyn, pp. 7-8)*

Here, Evelyn remembers that with the very first client she was afraid of physical attack (see the quote above, p. 7); however, that was the only frightening experience she had. She goes on to talk about a different kind of fear, though – the fear of psychological attack – which relates back to the sub-theme above. Yet, even this fear seems to have gone away, perhaps as a result of her gaining experience and mastering control and awareness over her reactions towards clients. In fact, most participants made a point that fear, particularly the fear of physical violence, was only associated with their very early experiences, but which was absent from their current practice.

> *I never felt afraid, because I think they are so much more likely to do something to themselves rather than to, to, to us than do to others (James, p. 21)*

It seems that experience is the solution to counter the initial fear of working with clients diagnosed with schizophrenia. It seems that as newly qualified practitioners enter the field they are influenced more by public opinion, particularly the media, which often portrays people diagnosed with schizophrenia as mad and dangerous. Establishing an emotional relationship ('getting to know the human part') allows a practitioner to make his or her own judgement. Yet, not all are spared from fear, as the chaos and unpredictability may present challenges to which a practitioner will respond with fear no matter how experienced he is in the field (as suggested by Ryan).

MASTER THEME 2: SYMBIOTIC RELATIONSHIP

In this master theme a number of various ways in which both clients and therapists benefit from the interaction are discussed. The fascination that participants expressed seems to feed therapists' curiosity about the human mind; affection and compassion towards this vulnerable client group seems to activate therapists' own wounds and vulnerability, giving them a sense of mastery and potency. Finally, therapists' personal history appears to play a role in attracting them to this field of work. All these aspects suggest that therapists get something important out of the relationship with the client: different things for different therapists, and some gain more than others. They also believe that the work is highly beneficial to the clients. None of them doubted the usefulness of the work they did and continue doing with their clients diagnosed with schizophrenia. As a result, a symbiotic therapeutic relationship is established between the therapist and the client whereby everybody wins. It should be noted, however, that this study focused exclusively on therapists' experiences. Thus, only therapists' opinions on the treatment are expressed here. It is acknowledged that interviewing clients about the usefulness of psychotherapy would have provided a fuller account. This will be further explored in the discussion section below.

Fascination

The previous master theme attempted to capture the 'dark side' of working with schizophrenia: the chaos, psychological threat and fear involved in this kind of work. The threat was particularly evident in the 'From confusion of minds to catastrophe' sub-theme, where the psychological danger was skilfully captured in words by the participants. However, the type of danger the participants talked about did not seem to repel them; on

the contrary, it fascinated and captivated the participants. This theme elaborates on what draws participants into this field of work.

David started his interview with the following phrase:

> *For whatever reason I was always haunted by the possibility of madness from childhood onwards (David, p. 1)*

> *it's powerful stuff … it fascinates one because it's, it's the very stuff of the emergence of consciousness … most people want to stay within the cultural norms and not go into this dark territory (David, pp. 16-17)*

He talked about the curiosity and fascination with the concept of madness, and how he would like to understand this experience in more depth. Again, as in his description of a sense of catastrophe above, there is a sense of something supernatural that he sees in 'madness' and that fascinates him. Later in the interview he added:

> *I was fascinated with the symbolism of schizophrenic discourse (David, p. 2)*

Although he said later on in the interview that a therapist in this type of work has to "go through hell" (David, p. 19), the reward of this ordeal, David believed, is a fascinating and illuminating journey of discovery about the human psyche.

Evelyn started her interview by stating that

> *they are my favourite clients to work with … I find it the most stimulating work that, of all the work I do… it's such a lively work ... it's lively sort of intellectually but it's also lively in kind of emotional and psychological sense (Evelyn, p. 1)*

> *I do remember just sort of being kind of drawn to it, fascinated by it [working with schizophrenia and psychotic clients] (Evelyn, p. 26)*

These quotes suggest curiosity, intellectual challenge and a sense of being alive; it seems that this kind of work activates all her senses, including intellectual, psychological and emotional involvement. James also said that this client group is his 'favourite', and described feeling drawn to and fascinated by people diagnosed with schizophrenia:

> *I find very, something very particular about them, there is something very different about them and I often find, I am often very fascinated by their sensitivity, I find them very sensitive as a, in terms of their personality and I often find that there is a lot of, they are quite vulnerable and, and, and that what I think hooks me (James, pp. 2-3)*

> *these are really interesting people (James, p. 18)*

It would seem that James found the vulnerability and sensitivity of people with schizophrenia particularly appealing. His repetitive reformulation of the sentence and use of 'and' suggest that he struggled to define what it is exactly that fascinated him.

> *I really enjoy that part where you together make sense of it and together, amm, and if you are able as a therapist to take away a little bit of that, amm, shame and that anxiety they feel, often in my experience I find it hugely rewarding (James, p. 4)*

In this quote James talks about how much he enjoys the work. Taking away a client's shame and anxiety feels rewarding; it almost suggests rescuing the client from painful feelings, giving James a sense of potency and making his work worthwhile. It appears that the work is highly rewarding for therapists, whereby they benefit as much if not more than

the clients do. This suggests a symbiotic quality of the work with people with schizophrenia and psychosis; thus, both clients and therapists gain something important for them.

However, fascination with the disorder and working with this client group is not shared by all the participants. Melanie, who had some experience of working with clients diagnosed with schizophrenia during her training, no longer works with this client group. As she is currently in private practice, Melanie explained that she would not work in an inpatient setting where 'anything can kick off' at any point, and that this type of setting is not right for her: "something about that chaos feels too much" (Melanie, p. 24). Therefore, there was a divergence in participants' views on the chaos of schizophrenia. Those participants who found the work fascinating did not seem to mind the chaos, but found it mentally stimulating, and felt emotionally connected to their clients; whereas for Melanie this chaos was off-putting. However, it is important to note that the context is crucial in this connection as Melanie referred to the inpatient mental hospital, which can be off-putting in itself, rather than the nature of working with people with schizophrenia per se. The data are insufficient to speculate on the impact of the setting on the practitioner's choice. This aspect will be further explored in the discussion chapter looking at the limitations of this study.

In this sub-theme, participants talked about what appealed to them in working with clients diagnosed with schizophrenia. There is something seductive about the danger and the challenge for some participants; and something intriguing about the vulnerability for others.

Affection, empathy and protectiveness

All six participants talked about their fondness and affection towards their clients diagnosed with schizophrenia. They also talked about caring for them, wanting to help them and feeling protective of them. These aspects of participants' experience are discussed further, below.

Ryan talked about the affection he feels towards his clients diagnosed with schizophrenia:

> *it was sort of affection … you come close to somebody for a while but then perhaps if you saw that person again you would retain, you know you would realise that you retained something of them … Such an intense kind of relationship, amm, that I find that one often feels deep affection for them and they are struggling (Ryan, p. 11)*

In this quote Ryan mentions retaining something of the client, which echoes the confusion of the minds discussed in the sub-theme 'From confusion of minds to catastrophe'. It seems that this confusion of minds makes him feel closer to the client and identify with his struggle and pain. Ryan described it in the following passage:

> *the thing which I like about working with … people with psychosis is not really that they've got a psychosis, it's that they are suffering that ... they are suffering and that somehow makes me want to help them, try to help them (Ryan, p. 21)*

The desire to help the client seems to come from the identification with the distress, with clients' suffering. This also highlights the role of the therapist's personal story in the motivation to work as a therapist, and the affinity with a particular client presentation. This will be discussed further in the following sub-theme.

Similarly, Evelyn talked about her compassion and empathy for the struggles of her clients:

> *on an emotional level the thing I would usually most be feeling at times like that would be, you know, heart-break, you know, you feel sort of heart-broken for how, for what they are experiencing (Evelyn, p. 19)*

James felt particularly protective of his clients diagnosed with schizophrenia:

> *I notice in myself that I am a little bit more protective of them (James, p. 5)*

> *it's something you always try to do as a therapist, you know, to be authentic, straightforward, amm, you know, as honest as possible, but I think with them I feel I have to do it even more in order not to give them any, amm, not to encourage any jumping to conclusions (James, p. 5)*

In his description of feeling protective it is almost as if he is taking on a parental role, whereby he wants to look after his clients and simultaneously empower them. He acknowledges the danger of overprotecting clients and consciously tries to avoid infantilising them. Thus, James highlights the importance of finding a balance between accommodating clients' vulnerability and sensitivity and treating them as capable individuals:

> *it's important, you know, not to overprotect ... I worry about that there is a sense of being overprotective and overly careful so I think you have to find a balance (James, p. 6)*

Similarly, Emma talked about her desire to rescue her client ("I had to bracket myself in terms of trying to rescue her" – Emma, p. 2) and the compassion and sadness she had for

people diagnosed with schizophrenia, as she felt that in our society they do not receive the necessary support and acceptance:

> *I feel a lot of sadness for people with those diagnoses, I feel that somehow through whatever experiences they have had that, perhaps, their opportunities to develop their sense of self, perhaps, may have not be as strong as those of us who don't experience it (Emma, p. 11)*

Melanie talked about her desire to help, and the powerlessness that she felt:

> *there was feeling of powerlessness, of wanting to do something to make it better but not being able to (Melanie, p. 12)*

Overall, it seems that this client group deeply affects the therapist, eliciting compassion, empathy, affection and the desire to help and protect. Participants indicate that it is the vulnerability of people diagnosed with schizophrenia that elicits these warm, caring feelings in the therapist. The vulnerability of this client group seems to come not only from the symptoms of their distress, but also the environment they live in: the social position occupied by people diagnosed with schizophrenia, where they are often deprived of rights and resources. It would seem that this aspect of their existence activates some of the best human qualities in the therapist such as humility and compassion for the other. We all know what it means to feel pain and to suffer; participants pick up the pain and vulnerability in their clients and, perhaps as an attempt to mend their own wounds, strive to help their clients. In this regard, this aspect of participants' experience was assigned a symbiotic quality.

The importance of the relationship

In the current mental health system, where clients tend to receive sporadic treatment, and where interventions are administered by a number of different members of staff, participants in this study all highlight the importance of a therapeutic relationship with the client, its value and therapeutic benefits. This sub-theme captures participants' views on establishing a relationship with clients diagnosed with schizophrenia. In the quote below Melanie described her relational approach to working with schizophrenia:

> *it's all about finding a way in, and I think, I think that's how I would make sense of working with schizophrenia, I need to find a way in to connect with a client as a human being, not, not just to see them as a set of symptoms, and I think that's something that can, can get missed (Melanie, p. 17)*

She stressed the therapeutic role of the relationship:

> *the healing component was, for her [client] to have a relationship with somebody (Melanie, p. 4)*

In some accounts the importance of forming a relationship was implicit, where participants were rather critical of the custodial care and medication approach to treatment employed in mental institutions. Since the relationship with the client was seen as paramount by all participants, the medical model – where this aspect of work is largely ignored – was portrayed as an enemy, making only a counterproductive contribution to the treatment of individuals diagnosed with schizophrenia.

> *I think part of the problem with people diagnosed with schizophrenia is that they become part of the system, and the only way that the medical approach … is to treat them through medication. I don't believe that the medical approach believes*

> *in a therapeutic approach ... [in an ideal situation] greater benefit for people with psychiatric diagnosis is to be in an environment they feel supported and allowed to be feeling without, kind of, being medically numbed through the toxic drugs that they've given to stabilise them (Emma, pp. 11-12)*

Participants view their relationship with a client rather differently, highlighting diverging views on emotional closeness that exists between the therapist and the client diagnosed with schizophrenia. Ryan saw the relationship primarily in terms of object use, and highlighted his dissatisfaction and disappointment:

> *… difficulty of forming a real relationship with the person. [It] is probably more to do with my desire ... because I didn't get enough out of it, I don't get enough out of the relationship probably. Amm, it's a very selfish [Researcher: What did you hope to get out of it?] A relationship, I suppose, that is somehow reciprocal, and it's probably never really reciprocal, it's not always a 100% true but, amm, it's largely true, you can't form a sort of relationship you would form with a neurotic person and so you don't get satisfied from the relationship, a psychotic person doesn't really, doesn't really care for you, you are not really a person in a sense, you are more of an object. There is something lacking in that ability in a sense (Ryan, pp. 17-18)*

Ryan's account above is opposed to James' view of the relationship with a client diagnosed with schizophrenia, where he described feeling a strong sense of closeness:

> *I feel this sense of connection, a sense of closeness that I really enjoy, it's not like with, sometimes with other patient groups; you have to work a lot through defences … their coping styles, of, you know, let's say, borderline patients who can*

> *be very aggressive or can be very critical or and that's all part of … the issue, but takes a lot of time to get there, you know to get there to what's behind it … and I felt that with those patients [with schizophrenia and psychosis] I often feel it was not necessary, that there was … straight away a level of closeness or trust (James, pp. 18-19)*
>
> *when I think about them what stays with me is really a sense of closeness. I can't describe it in any other way (James, p. 23)*

and that the work, as a result of this relationship, was highly rewarding for James:

> *[I] find if you manage to get a good rapport, good therapeutic relationship, good alliance then I think the work is extremely fulfilling as a therapist ... because actually they are quite willing to work quite closely with you (James, p. 3)*
>
> *you settle and you build the relationship and that's something I really, really enjoy (p. 25)*

In this sub-theme there appears to be a discrepancy in how the participants see the relationship with clients diagnosed with schizophrenia. On the one hand Ryan highlighted the limitations of this client group to form a 'real' relationship; on the other hand James stressed the particular sense of closeness and connection specific to this client group.

Personal history as therapist's motivation

This sub-theme explores the impact of participants' personal experiences on their desire to work with people with schizophrenia. Most participants conveyed the idea that their experiences of personal struggles helped them understand their clients better, or attracted them to this field of work. In the passage below Ryan talked about what unites him to

people with psychosis. It seems that his experiences as a suffering child were directly related to his desire to rescue his client and mend his pain, perhaps as a way of mastering his own trauma:

> *I think the thing which I like about working with ... people with psychosis is not really that they've got a psychosis; it's that they are suffering … and that somehow makes me want to help them, try to help them. I think that's because I was suffering as a child, I was suffering, I was not in a deprived family, nothing, rather the opposite, but emotionally somehow I was suffering, struggling, nobody was helping me, and I think it left a big imprint on me, one's early childhood experiences, I think they leave an imprint and I was fortunate later ... very kind older people that helped me and helped me to, you know, do well academically and stuff like that but not just that but to find myself, to find myself, and I suppose I am trying to do that with other people who are suffering (Ryan, pp. 21-22)*

Evelyn grew up with a mother who had a psychiatric diagnosis; therefore, she had a more direct and intuitive knowledge of severe psychological distress. When recalling the difficult times of living with a mother going in and out of hospital and not receiving any support from either the professionals or the family, Evelyn reflected on how this impacted on her career (and the choice of career) as a psychotherapist:

> *there was an unresolved need to get control of this situation, understand it, find or maybe discover some way to … help … because obviously I was only a child I hadn't way to help so I just used to, sort of get in there and try be with her, aamm, so I think on one level that is part of what drew me into this [field of work] ... I'm then not just, aamm, being with people with this sort of extreme states of mind but I am learning ways to help people or to make responses (Evelyn, pp. 25-26)*

Evelyn was saying that being a therapist is empowering, because she has some degree of control and the resources to help which she did not have when she was a child. The need to master past trauma and a sense of helplessness became motivating forces in her desire to help clients. Moreover, her direct experience of living with a loved one also helped her not to fear people in extreme states of mind:

> *part of why I liked it was because I wasn't scared of it; I didn't, it didn't feel that sort of unfamiliar to me (Evelyn, p. 26)*

James also talked about the affinity he felt with the struggles of people with schizophrenia:

> *I think based on my biography I can, this whole question of perception … I can see some links, I mean I never, you know, never experienced it, thank God, but, but I can I can relate to it a little bit in terms of, you say some things and others perceive it differently, so I do think there are some, I can relate to it a little bit, I do sometimes wonder whether, therefore, I can understand it to some extent just the sense of, amm, yeah, feeling unsafe or feeling people don't understand around you (James, p. 16)*

In this sub-theme there appears to be a link between participants' experiences and the sense of affinity they feel towards the clients with schizophrenia and psychosis. This shows how similar people are, and how even the most extreme states of mind seem akin to the ordinary human struggles and desires to feel understood and accepted, to avoid loneliness and suffering, and to establish emotional closeness with significant others. There is also a sense that participants get more out the relationship with the client than does the client. These aspects will be explored further in the following chapter.

Benefits of psychotherapy for clients

Thus far we considered the benefits to the therapist whereas this final theme explores the complimentary side of the symbiotic relationship - the benefits of psychotherapy to the client. All participants conveyed the idea that they believe in the positive value of psychotherapy for people with schizophrenia and psychosis. They pointed out the need to be realistic and accept that all the symptoms might not go away. Yet, participants unanimously expressed their confidence that psychotherapy can significantly improve their clients' wellbeing and contribute to recovery.

Evelyn stated her view on recovery as opposed to the concept of 'cure', and her confidence in the work:

> *the recovery where the person may continue to have some symptoms or some unusual experiences but their sort of condition or their predicament doesn't dominate their entire life and they can have a, you know, a reasonable, a life worth living. That type of recovery – yes. That is 100% achievable, doesn't mean it is going to be achievable for every single individual but it is definitely achievable and I go in to every piece of work on that basis (Evelyn, p. 24)*

She further acknowledged that not many therapists attempt this work, and that as a result there is not enough support for people with schizophrenia. She almost sounded pleading, highlighting the neglect within psychotherapy when it comes to this client group:

> *I would sort of really, really want to encourage therapists to do this type of work because it is so needed (Evelyn, pp. 28-29)*

James enthusiastically listed a number of achievable goals, stressing that the prognosis for this client group is higher than generally expected:

> *I think an awful lot can be achieved, I think apart from, you know, getting them understanding their disorder, getting to an understanding of what happened to them, processing potentially very difficult feelings they had about their first admission … obviously on a symptom level later on in therapy I think you can work on things like, you know, behavioural activation, amm, structure, building a structure is very important, because … they are often very withdrawn … when it comes to delusions, I think there is a lot you can do … making sense of the content of the hallucinations is very important as well, because there is always a link to you know, their biography or their bigger themes … so I think, I think there is an awful lot that can be achieved (James, pp. 9-10)*

All other participants also conveyed, in some way or another, their confidence that psychotherapy is useful and helpful for people with schizophrenia. Most were rather critical of the medical model, pointing out the limitations and even potential damage of a non-therapeutic approach to care. An extract from Emma's interview, presented above to demonstrate the sub-theme, 'The importance of the relationship' is also relevant here (pp. 92-93). Overall, there seemed to be a consensus on the beneficial value of psychotherapy with this client group.

This master theme 'Symbiotic relationship' unites different aspects of therapists' experience, demonstrating mutual benefits to therapist and client in therapeutic work. It is obvious from the accounts that the client means a great deal to the therapist personally. In this regard, these aspects of participants' experience were assigned a symbiotic quality.

MASTER THEME 3: CONTAINMENT

Following on from the master theme 'The dark territory', where participants described the difficulties in tolerating the chaos, confusion, sense of feeling lost in an alien territory, feeling off the ground and even fearing losing their sanity, this theme looks at the ways participants attempt to contain themselves, their clients and the therapeutic process in the face of such challenge and threat. In the first sub-theme, 'The role of theory in trying to make sense of schizophrenia', participants highlighted the need for theory in order to ground themselves and manage their own emotional responses. In the second sub-theme, 'Containment through supervision', participants highlighted the crucial role of an experienced supervisor in helping them make sense of what is going on in therapy with clients diagnosed with schizophrenia. Finally, in the third sub-theme, 'The abandoned client group: need for training', participants placed emphasis on the lack or even absence of any sort of training on working with schizophrenia and psychosis, and highlighted the importance of such training to help the therapist cope.

The role of theory in trying to make sense of schizophrenia

All participants highlighted the importance of theory in helping them to make sense of schizophrenia and manage their own experience. Throughout their narratives participants barely used terminology or diagnostic labels when describing their experience; this may suggest that they did not find technical language useful in making sense of their and their clients' experience. As opposed to categorisations and technical jargon, participants seem to have found it useful and even essential to gain insight into clients' experience. In this regard, participants indicated that they found clinical literature useful, which attempts to capture clients' processes. It appears that this theoretical grounding is essential in

sustaining their capacity to withstand the challenge, and it almost does not matter what theory it is, as long as it serves as an anchor. Evelyn advised:

> *You are often working in utter, unbridled chaos; you need a really strong theory or a set of really strong theories to be able to go back and make sense of what's going on (Evelyn, p. 28)*

Here, Evelyn talks about the challenges of working with schizophrenia, relating back to feeling lost, confused and not knowing how to respond ("unbridled chaos"), emphasising the belief that drawing on some theory might help her understand, and so ground herself. David mentioned a number of psychoanalysts who were influential in his learning about schizophrenia and psychosis, including Freud, Jung and R.D. Laing. He was making sense of his strong reactions, which often occur in therapy with psychotic clients, in psychoanalytic terms, such as countertransference (the role of transference and countertransference was also acknowledged by Melanie, Emma and Evelyn):

> *you have to go through long process of learning to manage your own countertransference and being tranquil with it and ... anyone who works in this area needs to develop their own theoretical base to make sense of what's going on (David, p. 20)*

This also raises the issue of self-awareness, where personal therapy, theory and supervision become indispensable. Emma drew on attachment theory to help her make sense of schizophrenia and her clients' difficulties:

> *I believe that if there is huge disturbance in the initial stages of a child's development in relation to their attachment figure, I think that can lead to a*

> *situation where a child will develop a sense of finding the world unbearable (Emma, p. 6)*

Ryan used his understanding of 'madness' to guide his interventions, thus orienting himself in the work:

> *madness is a structure, it's not just a set of symptoms, [a] psychotic person doesn't really ever become non-psychotic, but that's the way their psychic world is structured (Ryan, p. 16)*

> *not to think of the symptoms as something that, delusions as something that's bad, needs to be removed, but trying to, but that's something that is sustaining them (Ryan, p. 15)*

However, Melanie acknowledged the limited power of theory, and that, despite it helping the practitioner to understand, to an extent, what is going on, does not solve the mystery of schizophrenia. The client's experience remains unknown:

> *I can make sense of it from an intellectual perspective in terms of knowing what the typical predisposing things are that might lead to it. I think in a way it's actually sitting with the unknown (Melanie, p. 15)*

and the work itself remains chaotic:

> *I think within the literature, within what's written it's very medicalised models of this is typically, is very symptoms based, amm, perhaps that's how professionals manage the, the unknown, is to try and create some structure amongst what can be chaos (Melanie, p. 16)*

In this sub-theme all participants acknowledged that a strong theoretical base is indispensable when working with people diagnosed with schizophrenia. Despite its limitations, theory seems to protect and ground the therapist by making the unknown, bizarre and alien phenomena more tolerable and understandable. On the one hand participants seemed to be saying that there is nothing that can prepare you for this type of work – the chaos and bewilderment are to an extent inevitable (as demonstrated in the first master theme, 'The dark territory'), but on the other hand the theory is not only useful but essential.

Containment through supervision

Nearly all participants emphasised the role of good supervision in supporting the therapist in this field of work. Supervision appears to be another lighthouse in the dark territory. For example, Evelyn advised:

> *You've got to have really, really top quality supervision with somebody who has worked intensely and intensively with people in those mental states because you need that grounding (Evelyn, p. 28)*

James pointed out the fear factor, which was addressed in the first master theme:

> *work with a supervisor who is not afraid or has worked with patients who suffer with psychosis (James, p. 19)*

David also advised on top quality supervision with someone experienced in the field:

> *[you need] good supervision. If a supervisor doesn't get it, change supervisors. You need a supervisor who gets this. There is no use trying to work in this area with someone trying to fit it into classical contact work (David, p. 20)*

In this sub-theme, participants highlighted the importance of having a supervisor who 'gets it', who is not afraid, and who has experience of intense work with psychosis. This need for 'top quality' and psychosis-specific supervision suggests that the challenges of working with schizophrenia are different from those that are commonly encountered with the 'worried well'. The chaos and 'alienness' of schizophrenia, as well as the fear, make the work particularly challenging for a therapist, thus intensifying the need for extra support, grounding and containment from a supervisor.

The abandoned client group: need for training

Training is an essential aspect of work for both counselling psychologists and psychotherapists. Apart from being a requirement (all qualified practitioners have to commit to continuous professional development throughout their careers in order to maintain and develop their knowledge and skills), it is widely acknowledged that training serves as an anchor containing and supporting practitioners in their work. Both the initial and the ongoing training emerged as a salient aspect of most participants' experience when working with clients diagnosed with schizophrenia. Participants reported that they did not feel prepared by their training institutions to work with schizophrenia, psychosis or psychotic experiences. James, the only participant whose training addressed working with psychosis and schizophrenia (trained in Germany), felt that the training was misleading, marginalising this client group as unsuitable for therapy, whereas most other participants did not receive any training at all.

Evelyn talked about how difficult it can be for therapists to get into working with clients diagnosed with schizophrenia, and noted that her training entirely neglected this area of work:

> *there are lots and lots of barriers and hurdles, you know, for individual therapists that might sort of think, you know, maybe could I [work with clients diagnosed with schizophrenia]? I mean for one thing the whole of my 4-5 years of training we never had any training about working with psychosis, it wasn't even on the agenda ... I thought that was really, really wrong. I did my master's dissertation on working with psychosis but I did it because I was interested, not because it was something on the curriculum (Evelyn, p. 29)*

James felt that his training institution cautioned therapists against this client group, which seemed to suggest these clients were untreatable and beyond technique, thus naturally slightly discouraging therapists from working with this client group. He emphasised that with a bit of creativity the therapeutic techniques could be adopted and used effectively in the work:

> *there was always a little bit of a sense of this is all good for these client groups, you know, borderlines, or, you know, CPDs or depression or anxiety, but be a little bit careful with, with, with schizophrenic patients, so there was always this sense of be careful (James, pp. 14)*

> *quite a neglected group in therapy, in terms of our training (James, p. 6)*

Emma also encountered difficulties in trying to gain experience of working with this client group during her training, as the placement opportunities were not set up (here she was talking about the time of her training in 2003-2004):

> *when I was studying I, I wanted to do at least a placement at a mental hospital, but the opportunities weren't available and a lot of mental hospitals … at that point*

> *they didn't offer placements to trainee therapists, it was more kind of clinical support and kind of mental health nurse practitioners (Emma, p. 13)*

The fact that schizophrenia and psychosis are not addressed during psychotherapists' and counselling psychologists' training suggests that potentially fewer practitioners would feel confident to work in this field, thus making this client group marginalised and deprived of the option to receive psychotherapy as part of their treatment path. In the following passage James noted this lack, and encouraged therapists to work with people with schizophrenia and psychosis:

> *I think … as a profession, I think we need to make sure that we are not neglecting any, any groups of patients and we don't just think as psychotherapists or therapists that, or we can't work with them, and all they need is medication; I think medication is part of it, yes, or can be, but I don't think we should just leave them (James, p. 23)*

In this sub-theme, participants highlighted that training institutions did not prepare them to work with people diagnosed with schizophrenia in terms of addressing this in the curriculum and providing placement opportunities.

Overall, the role of supervision and theory and the lack of training on working with schizophrenia have been explored. It has highlighted that participants gain a sense of reassurance from supervision, and grounding from theoretical knowledge on this condition. Participants also highlighted that this area of work was largely ignored in their training. Hence, theory appears to be crucial in containing the practitioner in this field of work; it therefore seems odd that training institutions do not provide trainees with a

theoretical base when it comes to schizophrenia and psychosis. These aspects will be explored further in the following discussion chapter.

Conclusion

In this chapter, the three master themes and constituent twelve sub-themes have been explored, and illustrated by close analysis of participants' experiences. The first theme, 'The dark territory', discovered that participants often experience this type of work as alien and utterly chaotic, and characterised by rich, powerful experiences that were alarming, especially at the beginning of participants' careers. The second master theme, 'Symbiotic relationship', revealed how emotionally involved the participants are with their clients, and that therapeutic relationship in psychotherapy with people diagnosed with schizophrenia is mutually beneficial. The final theme, 'Containment', exposed the needs of the practitioners in this field of work, including specialist supervision and additional training. It is noted that this account is not exhaustive or conclusive, and it is recognised that different researches might have focused on different areas of participants' experiences.

DISCUSSION

This section discusses key findings in relation to existing theoretical literature in this field. This is followed by the review of the clinical implications of the findings that have emerged from the study for the field of counselling psychology, and especially for those practitioners working with people diagnosed with schizophrenia. The reflective considerations and methodological critique of this study are then addressed. Finally, suggestions for further research are discussed. A number of areas of interest were uncovered within the analysis; however, the aspects most relevant to the research question are given focus here. From the analysis presented in the previous chapter three master themes have emerged, namely, 'The Dark Territory', 'Symbiotic Relationship' and 'Containment'. On the one hand, participants experienced the work with people diagnosed with schizophrenia as an ordinary work of psychotherapists, yet on the other hand it felt alien, utterly chaotic and rich in powerful experiences that were alarming at the beginning of the participants' careers. The threat of enmeshment with the client and confusion of minds was a common and powerful experience. Psychological danger, fear, confusion and chaos, although undoubtedly challenging, did not result in the participants becoming overwhelmed to the point of being unable to function.

It seems that it was the 'fascination with madness' that allowed the therapist to overcome the fear. The danger fascinated rather than repelled. Participants did not refer to the symptoms of schizophrenia as posing a risk or becoming a hindrance to the therapeutic relationship; although, contrary to the other participants, Ryan suggested that these clients are unable to form a real relationship with a therapist. The analysis demonstrated how emotionally involved the participants were with their clients, and this was evident in the protectiveness, affection and care they felt towards their clients. Despite a number of

realistic difficulties, participants demonstrated restrained optimism in the psychotherapy with people diagnosed with schizophrenia. Finally, all participants emphasised the need for grounding through theoretical understanding, training and top quality supervision. Potential implications of the themes that emerged will be explored in the sections below. Naturally, some divergence was discovered in the above themes, and this will be explored in more detail in the methodological considerations section below.

The Dark Territory

> *He [a person with schizophrenia] reveals the darkness and the dread of the human condition and fabricates a new symbolic transcendence over it. This has been the function of the creative deviant from the shamans through Shakespeare*
>
> (Becker, 1973, p. 220)

A number of participants referred to the importance of gaining experience in working with clients diagnosed with schizophrenia to help them deal with fear and a sense of psychological danger. For example, Evelyn and Melanie pointed out how at first they felt terrified, and that with time fearful emotions were no longer present in their work with people diagnosed with schizophrenia. Earlier studies support the differences between the reactions of experienced and inexperienced therapists; for example, in a factor analytic study Farber and Heifetz (1981) note that inexperienced therapists acknowledge feeling personally depleted by the work more than do experienced therapists. Brody and Farber (1996) conducted a quantitative study using questionnaires and vignette and they report that inexperienced clinicians, students and interns are more likely to feel that their emotions are too strong and too frequent, and so need to be defended against. In line with this earlier research, the participants in this study reported being affected by the work to a

greater degree at the beginning or their careers; in particular, many identified fear as an initial overreaction primarily due to inexperience. Notwithstanding this fact, the issue of experience of working with clients with schizophrenia had a significant impact on most participants.

It is noted in the clinical literature that working with schizophrenia has a strong impact on the practitioner. For example, some writers suggest that Sigmund Freud was scared of working with people with schizophrenia, and for that reason avoided working with this client group (Karon, 1992). Carl Rogers was brought to the edge of being psychotic after working with a young woman with schizophrenia; he handed the case over to a psychiatrist and took a few months leave (Kirschenbaum, 2007). In a recent article, Terry (2005) presented a clinical case study of his work with a psychotic client. Similar to the participants in this study he mentions the impact the client had on his ability to think, stressing that he often felt "mindless and paralysed" (p. 30). He confesses: 'I found it hard to make sense of any of this and hard to reach him [the client]… mostly I found it impossible to think' (p. 32). He reflects on this impossibility to think, attributing it to the need to contain psychotic aspects of client's emotional experience: "In the sessions with John my mind was consumed and deadened by unbearable concrete experiences" (p. 36). He explains, referring to Caper's work (1999), that, whilst containing the psychotic aspects of his client's experience, the therapist's mind temporarily 'joins in a delusion' with the client. The therapist remains in this state until released by a third perspective – for example, a supervisor; the third person is needed to disentangle the therapist from the client. This need to disentangle resonates with the findings of this study on confusion of the minds and entanglement whereby therapists found themselves being drawn into the client's experiential field. Here again, supervision emerges as a crucial aspect of the practitioner's ability to stay sane and function effectively.

It emerged from the data that working with schizophrenia was simultaneously perceived as ordinary and alien. It can be argued that, despite the powerful reactions which therapists experience when in contact with individuals with schizophrenia, the work is still no different from the work they do with other clients. This supports some earlier observations; Rogers, Gendlin, Kiesler and Truax (1967), in their study on the therapeutic relationship with individuals with schizophrenia, state one of their most important findings:

> *We found them [clients with schizophrenia] far more similar to, than different from, other clients with whom we have worked. They appeared to respond constructively, as do others, to subtle and freeing elements in an interpersonal relationship, when they were able to perceive these elements.* (p. 93)

Feeling lost and not knowing what to do was previously addressed in earlier research literature. For example Gendlin (1967) describes therapists' experience in these words:

> *We wonder what to do with all this richness of events which occurs in our own moment-to-moment experience … We are in conflict, not knowing whether to push harder or to attempt being even safer. We blame ourselves for too much helpless waiting, then minutes later, for too much interruption, pressure, and demand.* (p. 372)

Not knowing what to do may lead to therapists feeling the need to be infallible – the pressure to know it all. However, similar to the view of the participants in this study it was previously noted that exactly the opposite is needed. Litz and Litz (1952) more than half a century ago noted that "the patient's needs to make the therapist into an all-powerful figure are so great … The strength in the therapist that must be conveyed to the patient

may well derive from sufficient integrity not to need to be infallible" (p. 173). Similarly, Ryan notes this pressure to know and mystically understand all about the client and what it all means, expressing it in the theme: 'You are flying by the seat of your pants' (p. 72).

The frequent inability to understand schizophrenic communication was also noted by Fromm-Reichmann (1952). She posits that difficulty in understanding the client, and feeling lost, can be for two reasons. In some cases, she argues, clients deliberately express themselves in ambiguous ways with an aim to "mitigate the burden of the anticipated possibility of being misunderstood" (p. 97). In other cases, the inability to understand is a result of the means of communication employed by individuals diagnosed with schizophrenia. She explains:

> *Their means of communication is different from that used by the non-schizophrenic psychiatrist, because of the different psychological frame of reference in which it is conceived. It is just as futile to expect to be able to understand every schizophrenic communication, however secretly meaningful one may consider it to be, as it is to expect to be able always to understand the latent contents of every dream, from merely listening to the language in which a person communicates its manifest contents. There dreamer and the psychotic live in a world which is psychologically different from the rational world of the healthy in their waking states.* (p. 97)

Fear emerged as a common experience for participants in this study, even though they emphasised different aspects and manifestations of that fear. Therapists' fear when working with clients diagnosed with schizophrenia or psychosis is repeatedly mentioned in the literature. Karon (1992) notes that when a therapist talks to an individual with schizophrenia "usually the therapist at least feels uncomfortable, depressed, and angry, because the patient does not react the way the therapist wants him or her to react … in

addition, the therapist feels scared and does not know why" (p. 194). This view is supported by the results of this study because fear emerged in different ways in most participants' narratives. One of the reasons why a therapist might feel fear with a client with schizophrenia is that fear is a client's feeling. This relates back to the literature on countertransference reviewed in the Introduction chapter (p. 28). Fear, and, even more often, terror, is the affect most commonly experienced by people with schizophrenia (Laing, 1960; Karon, 1992; Searles, 1965). Becker (1973) reflects on the experience of a person diagnosed with schizophrenia "for whom the burden of anxiety and fear is almost as constant as his daily breath" (p. 217) and highlights an extraordinary state of terror. Leader (2011) notes that the seemingly bizarre practices of people with schizophrenia and psychosis are indeed efforts to find a cure for those experiences of terror and fragmentation. Naturally, empathising with the client's terror inevitably fills a therapist with dread. Karen (1992) argues that most people don't want to know about schizophrenia because they "do not want to feel terror at that intensity" (p. 195). Karon (1992) in an article 'The fear of understanding schizophrenia', describes schizophrenia as a balancing between fear and loneliness (1992, p. 208), and argues that psychotherapy for schizophrenia is not fashionable because it makes therapists and the public at large very uncomfortable. She states, "What makes both professionals and the general public alike uncomfortable with schizophrenic people in not so much their difference from us, but their similarity. We do not want to know what they have to teach us about the human condition" (p. 191). She states that individuals with schizophrenia remind us about what we want to ignore. "To understand a schizophrenic person is to grasp painful facts about the human condition that we would rather not know, or, more frightening, to be reminded of painful facts we once knew, but repressed" (p. 192).

Fromm-Reichmann (1952) sees fear as a common experience which makes the work of the practitioner taxing. Similar to some participants' accounts in this study, she notes that fear can manifest itself in a number of ways. These include the fear of actual or potential violence, in either word or action, the feeling of being threatened by the content of the client's anxiety, or of being frightened by a client's ability to sense and seek out therapists' weak points and play upon them without words (p. 92). Potentially, this fear might distract the therapist from the client. Fromm-Reichmann warns that a therapist "may become too preoccupied with his own need for safety, security and prestige, hence too defensive and argumentative, to relate himself successfully to schizophrenic patients" (p. 92).

An interesting finding that emerged from participants' accounts, and has been explored in the sub-theme 'From confusion of minds to catastrophe', presents the client's mental disturbance as communicable to the therapist in the circumstances of a close therapeutic relationship. This phenomenon seems related to such rare psychiatric curiosities as *folie a' deux*, the dual psychosis, whereby the psychiatric symptoms of one individual are communicated to another over a long period of close association, and *folie imposée*, where there is a dominant person and an acceptor. These were formerly known clinically as Shared Psychotic Disorder, and are now Delusional Disorder, Shared in the DSM-V (APA, 2013). Furthermore, there are a number of documented instances of mass psychosis, where nations have been induced by mass persuasion to act irrationally or support irrational acts of others to the extent of "national psychosis" (Plunkett & Gordon, 1960). It is not suggested that the therapist's irrationality or distortion of reality whilst with the client is a sign of mental illness. It does seem, though, by virtue of projection and other unconscious mechanisms of communication, that the client's world view and experience are communicated to the therapist, whereby psychosis acquires a sort of

contagious quality. It is important to note that not all, but half, of the participants talked about such experiences. It seems that it is the degree to which each individual is susceptible and open to receive 'psychotic communication' that is key. It also seems that the susceptibility which makes such 'communication' possible varies from person to person, and might be related to the individual's personal history. Some research might be relevant in this regard, including research into empathic aspects of mental state attribution (the ability to inferentially model the mental states of others) and into mirror neurones. However, the data in this study are insufficient to speculate any further in regards to the mechanisms of such communication. It is merely noted that there seems to be a similarity between these phenomena. Thus, the tentative suggestion is that people influence each other, and such influence becomes apparent in participants' narratives, where half of the sample reported being impacted by the clients in terms of their perceptions and ability to reason. It is also worth noting that, apart from clients inducing disorganisation in their therapists' personality, the reverse may also be true: mental health and rationality are equally communicable by the psychotherapist (Plunkett & Gordon, 1960).

Regardless of the mechanisms of such communication, the participants in this study and clinical writers both suggest staying open to these 'contagious' qualities of psychosis and using it therapeutically. Little (1981) writes on the importance of therapists' openness to being impacted by seriously disturbed clients: 'Just as we need to enable psychotic or borderline patients to tolerate repeated temporary breakdowns, rather than encouraging them to expect to reach a stage where breakdown does not happen again, so we need to allow ourselves to regress, or break down' (p. 251). Here, Little emphasises that, however difficult the experience is (to the point of breakdown), the therapist should stay open to it; thus, therapist's capacity to help the client depends on therapist's ability to accompany their client into some of the most threatening parts of their souls.

The experiences presented in the sub-theme ‘From confusion to catastrophe’ resemble a description of therapist’s temporarily ‘going mad’ and ‘losing grip’. Maroda (2004) writes about therapists’ ability to ‘go mad’ with the client as essential in order to promote the client’s independence and growth. Searles (1959) argues that a person develops schizophrenia partially due to someone’s long-continued, unconscious effort to drive him crazy. This person is usually highly important in the client’s upbringing. He talks about various ways one can drive someone crazy, including initiating any kind of interpersonal interactions which foster emotional conflict in the person by simultaneously activating various areas of his personality in opposition to one another, and employing techniques which undermine ego-functioning such as double bind, the stimulation-frustration technique and sudden switching from one emotional wavelength to another. He proposes that patient’s social interactions with his or her family members, hospital staff and other patients on the ward, and in the dyadic setting with the psychotherapist, take the form of a mutual struggle to drive the other person crazy (p. 273). This, he explains, is a reconstitution of an earlier struggle between patient and parent taking form in the client’s evolving transference to the therapist. Searles further notes that the effort to drive the other person crazy is partially motivated by a desire to get rid of the threatening ‘craziness’ in oneself, partially by sadistic pleasure in rendering the therapist more or less disorganised, and partially by solicitude for the therapist. Based on his own therapeutic work and supervision of other practitioners, Searles concludes that any successful psychotherapy with a person diagnosed with schizophrenia includes a phase of this struggle for sanity. Similarly to the participants in this study he describes his experience in following remarks: “… I had to struggle with unaccustomed effort to maintain my own sanity … I became assailed with feelings of confusion and unreality …” (p. 274).

Symbiotic relationship

The symbiotic relationship of an individual with schizophrenia to a parent who utilises the client to complete her/his own life has received generous attention in the literature (Liz & Liz, 1952; Searles, 1965). Numerous psychoanalytic theorists focus on the symbiotic relatedness and, although emphasising different aspects, view the central conflict of clients with schizophrenia as originating in the infantile stage of symbiosis (Sherry, 1982; Searles, 1965; Bion, 1967; Rosenfeld, 1965; Laing, 1964; Arieti, 1974). In this study the master theme 'Symbiotic relationship' aims to label a type of a relationship between the therapist and the client, designating mutual dependence as opposed to other types of relationships, such as, for example, domination-submission or parasitic. Although mutual dependence might also be relevant when talking about psychotherapy in general, it becomes overwhelmingly apparent that participants in this study benefitted greatly from working with individuals with schizophrenia on different levels.

Searles (1965) draws attention to the intensely gratifying elements of the symbiotic mode of relatedness in therapeutic work with individuals experiencing psychosis, or who are diagnosed with schizophrenia. He describes in detail the processes of the establishment, maintenance and resolution of this mutual 'clinging' of both therapist and client to their symbiotic relationship. Some of these were summarised in the introductory chapter (see pages 33-35). Of interest here is the following remark by Searles (1959):

> *I find what the therapist offers the patient which is new and therapeutic, in this regards, is not an avoidance of the development of symbiotic, reciprocal dependency upon the patient, but rather an acceptance of this – an acceptance of the fact that the patient has to come to mean a great deal to him personally. It is*

> *this acceptance of one's own dependency upon him that the mother had not been able to offer him.* (p. 281)

It emerged from participants' narratives that therapists benefited greatly from working with clients diagnosed with schizophrenia, whether it was tapping into their desire to rescue and provide care, their own unresolved issues stemming from the past, or for enriching their understanding of the human condition. The finding on this point was somewhat similar to what had been found in earlier studies, both recent and older. For example, Gendlin (1966) notes the benefits of this work for the therapist's personal development: "It is well known that schizophrenic patients have a way of changing their therapists. They give their therapists powerful experiences, producing growth in them. I think also that if the patients fail to change us, if we hold up our professional images to such an extent that we do not let them change us, then I doubt very much if we are giving them the kind of relationship in which they can get better" (pp. 8-9). In a more recent qualitative phenomenological study, Laufer (2010) focused on the integrative or transformative properties of working with individuals diagnosed with schizophrenia for the clinician. She found that a client diagnosed with schizophrenia impacts on his therapist by prompting a transformative experience in which the therapist goes through personal change, by eliciting an experience in which the therapist gains knowledge about themselves and the human condition.

The results of this study seem to support Laufer's findings, that therapists gain valuable personal insights in this field of work. Participants conveyed their belief that they gained knowledge about what humans are really about, and saw the best and the worst of humanity. This sense of curiosity and wonderment seems to make the work fascinating

and stimulating for the practitioner. As Becker (1973) puts it, “this ‘disease’ is the one that most intrigues and fascinates man” (p. 220).

This, of course, can be said about any client group and any therapist’s general motivation to work as a psychotherapist. However, it seems that choosing to work with the most disturbed client group is linked to particular needs of the therapist. Therapists’ personal history of emotional difficulties, mental illness in the family and so on probably allow the therapists to identify with the client in some elements of past experience, and serve as an essential ingredient in establishing a profound rapport. The issue of therapists’ motivation for doing treatment is well discussed in clinical literature (e.g. Greenson, 1978). Maroda (2004) reflects on what therapists are seeking in making themselves available to the clients. Among other factors, she stresses therapists’ need to be transformed through the work with clients, to be healed and to heal “our old ‘afflicted’ caretakers as we heal our patients” (p. 38). The therapeutic situation provides the therapist with a sense of control, which a randomly formed relationship out in the world cannot. She reflects on therapists’ choice to stop working with the more disturbed clients, relating it to the therapists ‘healing’ themselves through their occupation and “no longer needing, on an emotional level, to take on the more damaged patients of the world” (p. 42). Therefore, she seems to be saying that therapists who choose to work predominantly with the ‘most damaged’ mentally ill are probably those most damaged themselves, and in most need of being transformed and ‘healed’ by their work. Searles (1959) also explores unconscious wishes on the part of the therapists, such as to foster personality disintegration in other people and to place unconscious investment in keeping clients fixed in their illness.

It was surprising that participants’ view of their client’s ability to establish a relationship with the therapist differed markedly, as illustrated where Ryan experienced the clients as

unable to form such a relationship. A relevant finding was reported in an earlier research project; Rogers, Gendlin, Kiesler and Truax (1967), in their mixed methods experimental study on the therapeutic relationship and its impact with individuals diagnosed with schizophrenia, noted that, as compared to 'neurotics', clients with schizophrenia in their study tended to perceive a relatively low level of understanding, acceptance and genuineness offered by a therapist. They concluded that deeply disturbed individuals with schizophrenia are unable to perceive or report understanding, warmth and genuineness to the same degree as the less disturbed client group, even when these qualities are present in the relationship. This finding may partially explain potential difficulties in forming a relationship with an individual diagnosed with schizophrenia. However, Ryan's opinion was rather an exception; all other participants agreed that a relationship with the client diagnosed with schizophrenia can be established, is rewarding and represents the main ingredient of successful therapy for this client group. In the same study mentioned above, Rogers et al. (1967) noted a difference in the way 'neurotics' and individuals with schizophrenia perceive the helping relationship, pointing out that the latter seem to be seeking a relationship they can trust. Thus, the therapist's potential as a caring, trustworthy person is crucial for the client, and the relationship with the therapist is pivotal (Kiesler, Mathieu & Klein, 1967, p. 297). Therefore, it seems that, although clients with schizophrenia might find it difficult to adequately perceive therapists' understanding, warmth and genuineness to the same degree as the less disturbed client group can, the clients nonetheless seek a relationship.

The findings suggest that the participants felt confident that psychotherapy with people diagnosed with schizophrenia is beneficial for the clients. Doubting their competency and ability to produce therapeutic change did not feature in the accounts. However, the participants stressed the importance of being realistic in this type of work and aiming for

recovery as opposed to cure. This is in accordance with existing literature. For example, Horowitz (2008) repeatedly points out the battle of balancing hope and expectation in the treatment of severely mentally ill with therapists' struggles and apprehensions about the meaning of their work. He writes about the clinician's anxiety over persistent feelings of ineffectualness, doubts, hopelessness and despair: "On countless occasions I have thought about the activation of will, about fanning a dying flame of desire and dislodging one from a state of near paralysis. Hope, in such instances, appears nearly extinguished and beyond revival" (p. 255).

The results of this study, however, did not demonstrate such concerns; none of the participants questioned the meaning and purpose of working with the clients diagnosed with schizophrenia. Their hope and confidence seemed unshakable. One possible explanation for not mentioning this aspect of work could be participants' reluctance to talk about their painful doubts about the efficacy and meaningfulness of psychotherapy. Current obsession with randomised control trials and measurements of efficacy might be putting a pressure on the practitioner to perform effectively and hide difficulties associated with a failure of such performance out of fear that the service might be withdrawn or lose funding. Additionally, Horowitz (2008) argues that the biological revolution in psychiatry is partially responsible for the disappearance of this discourse, shielding psychotherapists from self-examination, and preventing scrutiny of the inner workings of the psychotherapy of the severely mentally ill. Consistent with participants' views on recovery, as opposed to cure, Horowitz (2008) writes: "Certainly a principal feature of therapy with the seriously mentally ill is trying to ascertain what is attainable. Expecting too much causes disappointment; expecting too little breeds hopelessness" (p. 249).

Clinical implications for counselling psychology

The final master theme Containment is directly linked to the clinical implications of this study; therefore, the role of supervision, theory and training in clinical practice, as it emerged from the data, will be reviewed in this section.

The research posed a question about how psychotherapists and counselling psychologists experience the work with clients diagnosed with schizophrenia. As identified by Strawbridge and Woolfe (2010), counselling psychology can be distinguished in three main areas; namely, the awareness of the role of the therapeutic relationship, the questioning stance adopted towards the medical model and movement towards a more humanistic base, and the promoting of well-being as opposed to the sole focus on sickness and pathology. James (2013) further points out that relational emphasis and empathy are paramount in the practice of counselling psychology. Taking these into account, a number of clinical implications for counselling psychology practice follow. It is noted, however, that a different researcher may make different interpretations. Moreover, Wolitzky and Eagle (1997) argue that generalisations that emerge from psychotherapy research offer little guidance to a practitioner "dealing with the exigencies of a particular case" (p. 68). Therefore, the below recommendations are offered tentatively.

The therapeutic relationship has emerged as an important ingredient of psychotherapy. This is contrary to the dominant medical conceptualisation of schizophrenia as a bio-medical disorder which denies the usefulness of psychotherapy and the therapeutic relationship (Repper, 2002). Participants alluded to the medical approach with dismissive comments, which indicates their negative attitude towards this model; they accused it of using medication to suppress the individual's thoughts and feelings and denying them an opportunity to explore their difficult experiences. For example, this is evident in Emma's

interview, where she said: "… being medically numbed through the toxic drugs that they've given to stabilise them" (Emma, p. 12). Thus, the therapeutic relationship was deemed to offer something that standard mental health care could not. Moreover, Johansson and Eklund (2003) reported, based on the results of their qualitative study, that clients diagnosed with schizophrenia view the therapeutic relationship as the most important element of psychiatric care. Hence counselling psychology training encourages trainees to attend to the therapeutic relationship throughout the course of therapy, acknowledging the nature of the therapeutic relationship as fundamental to the progress and outcome of theory (Lewis & Bor, 1998); it is therefore deemed reasonable for counselling psychologists to participate in the provision of treatment for individuals diagnosed with schizophrenia. Magnavita (2000) defines the relational approach as a therapeutic process which relies most heavily on the quality of the client-therapist relationship, as opposed to technique. The emphasis on the therapeutic relationship is in line with recent qualitative research on counselling psychologists' discourse around schizophrenia (Larsson, 2010). It is also consistent with the overall message emerging in recent literature on the importance of the therapeutic relationship, particularly in the work with people diagnosed with schizophrenia (see literature reviews conducted by Fenton (2000) and Hewitt & Coffey (2005)). These findings indicate the importance of using a relational approach in therapy with clients diagnosed with schizophrenia. Given that NICE recommendations favour CBT as an essential component of treatment for people diagnosed with schizophrenia, the work of Safran, who advocates a more relational CBT, is relevant in this connection (Safran, 1998; Safran & Segal, 1990; Safran & Muran, 2006; Katzow & Safran, 2007). Regardless of therapists' practiced modality, it seems important to be aware of, and focus on, the therapeutic relationship between the therapist and the client. This finding is also consistent with the NICE recommendation to "take time to

build supportive and empathic relationships as an essential part of care" (NICE, 2014, p. 581). Unfortunately, this recommendation is mentioned only fleetingly in the general care section of NICE guidelines, and is not emphasised in the psychological therapies options section.

Larsson, Loewenthal and Brooks (2012) argue that counselling psychology lacks history alongside the diagnostic categories such as schizophrenia and does not appear in the literature as a profession involved in the treatment of individuals diagnosed with schizophrenia, as opposed to psychiatry and clinical psychology. Larsson (2010) notes a general attitude within the NHS that counselling psychologists cannot work in secondary care. This is further supported by a general lack of knowledge among psychiatrists and clinical psychologists as to what counselling psychologists are actually trained to do; and as a result the profession is perceived to be unable to work with psychotic individuals (Lewis & Bor, 1998). In light of the findings of this study it seems reasonable to address the work with the severely mentally ill, including schizophrenia, within the curriculum of counselling psychology. This might promote trainees' interest in working in this field, as well as lift the reputation of counselling psychology as a profession capable of working with severe psychological distress. Participants in this study reported that their training did not adequately prepare them for working with people diagnosed with schizophrenia. This is consistent with Larsson's findings (2010); in his qualitative research employing discourse analysis he found that the training of counselling psychologists was seen as hindrance to working with individuals diagnosed with schizophrenia because the training institutions do not foster counselling psychologists' confidence in working with severe mental health issues.

There is also a lack of placement opportunities that could expose trainee counselling psychologists to individuals with schizophrenia and psychosis, as most trainees get their placements in the voluntary sector rather than in secondary care. Again, it seems that this area of clinical practice is inhabited by clinical psychologists as opposed to counselling psychologists. As a result, lack of teaching and placement opportunities leads to an assumption that the work with schizophrenia is done by psychiatrists and clinical psychologists, whereas counselling psychologists are not equipped to deal with schizophrenia. This seems particularly unfortunate because counselling psychologists' training focuses, as discussed above, on the relationship; and this focus on the relationship is precisely what seems to be valuable in the work with people diagnosed with schizophrenia. It seems that counselling psychologists are able to contribute to working in this field, and should be enabled and encouraged to do so by their training institutions. This could be achieved through changes to the curriculum to include teaching on schizophrenia spectrum disorders, and liaising with the NHS secondary care units to establish opportunities for the trainees to gain clinical experience with this client group. Finally, additional CPD opportunities for qualified practitioners would be beneficial.

Although the lack of training is evident, caution needs to be taken with regard to this recommendation. It emerged from participants' accounts that no amount of training, CPD courses and learning about theory seems to free the therapist from feeling 'lost in an alien territory' and from not knowing how to respond. Atwood, Orange and Stolorow (2002) write about a gulf of misunderstanding and invalidation which often opens up between the therapist and the client, which questions therapists' ability and skill and threatens therapists' perception of themselves as capable clinicians, undermining the significance of the training and experience they have gained so far. This sense of invalidation is extremely anxiety-provoking for the therapist. Thus, Atwood et al. (2002) point out a sense of

insufficiency or a priori lack in the qualities needed to work with this client group. Therefore, it seems that the training should address the complexity of such challenges for the therapists, rather than focus exclusively on technique. Furthermore, it seems a necessity to provide specialist supervision to allow space for therapists to express, process and normalise strong responses to working with clients diagnosed with schizophrenia. Organisational acknowledgment and validation of the impact of such work on the practitioner also seems important; a supportive collegial and supervisory stance (as opposed to expert and technical support) is required in helping the therapist to deal with this client group. Needless to say, supervision is consistently stressed as a crucial ingredient of effective and ethical clinical practice. When it comes to working with schizophrenia and psychosis, supervision seems to become a vital support for the practitioner. For example, Terry (2005), when talking about his work with a psychotic client, refers to supervision as a "sanctuary" (p. 32).

Finally, a brief comment on the general use of terminology in participants' accounts, which did not result in a separate theme but nevertheless seems important, is presented here to complete this section. It has been noticed that participants used terms such as 'schizophrenia', 'psychosis' and 'psychotic experiences' interchangeably, which suggests that differentiation between these terms seems insignificant in clinical practice. Such interchangeable use of these terms is also reflected in the literature. The term 'psychosis' is often used in the literature to refer to the group of psychotic disorders that includes schizophrenia, schizoaffective disorder, schizophreniform disorder and delusional disorder (NICE, 2014). Throughout the participants' narratives the diagnostic categories and labels were rarely used, suggesting that participants did not find them useful in talking about their experience. This is, perhaps, because few terms from psychopathology tell a practitioner what to do with such and such a client group. Gendlin (1967) notes that

categories of psychopathology are different from classifications of client in-therapy behaviour. He argues that the former offer little about how to approach a particular client, whereas the latter are clinically useful as they lead to a certain kind of theorist procedure, allowing colleagues to discuss their work with particular client in-therapy behaviour.

Critical methodological considerations

This section focuses on the methodological issues in this research, drawing on Yardley's (2000) guidelines, which were discussed in the methodology section above. The research methodology was selected for its appropriateness to the research aims in this study as it allowed for the provision of a rich and complex insight into the subjective experience of psychotherapists working with people diagnosed with schizophrenia. The current study is consistent with IPA methodology; therefore, it does not aim to provide generalisable results. Instead its objective is to provide a detailed account of experience of a specific group of psychotherapists and counselling psychologists working with clients diagnosed with schizophrenia.

It could be argued that the small sample was a limitation. However, such a sample size was considered appropriate in line with the ideographic nature of IPA and the suitability of this method for the investigation of the research question. The participants in the study are not, and were not intended to be, a statistically representative sample of the population of psychotherapists and counselling psychologists. However, the participants were carefully selected to increase the homogeneity of the sample. It remains unknown, however, whether their responses were 'typical' of the population. The issues discussed by the participants may not be pertinent for all therapists working with clients diagnosed with

schizophrenia, but it is believed that the findings have application to a considerable segment of that population.

In order to increase the homogeneity of the sample I was careful to ensure that all participants shared a specific lived experience by including only qualified practitioners who had worked with at least one client diagnosed with schizophrenia. Despite this, the experiences of participants varied in a number of ways. There are several factors which might have influenced the diversity of the accounts.

Firstly, all participants, except James, were British. James was born and raised in Germany, and, potentially, differences around emotional expression may have had an influence. Secondly, participants worked in a number of different settings throughout their careers, including private and state hospitals, inpatient and outpatient settings, private practice, voluntary organisations and therapeutic communities; they also drew on their experience of encountering individuals diagnosed with schizophrenia in a non-therapeutic capacity. They worked in several areas across the UK, Germany and Israel. This can potentially explain some of the diversity in the accounts. For example, participants who saw their clients in private practice (Evelyn) and in a voluntary setting (Emma) would be more likely to come across more functional people, as opposed to the patients on long-term stay wards of an inpatient hospital (David). This might explain the more intense accounts of experience (particularly, the feeling of 'overwhelming catastrophe') presented by David.

There were also differences with regards to the experience of working with the target client group. As recommended by Skovhold and Ronnestad (1992), all participants had at least five years' post qualification experience; they suggest that this is a significant cut off point in a therapist's development, whereby the therapist moves away from being too rigid

to becoming more authentic. Although this recommendation was followed, not all practitioners worked primarily with this client group; therefore, the number of clients diagnosed with schizophrenia that participants worked with varied. Ryan, David and Evelyn had the most experience, which potentially explains the more graphic accounts of their experience, as they were probably influenced by the work with their clients to a greater degree. David's and Evelyn's descriptions of those experiences are particularly evident in the sub-theme 'From confusion of minds to catastrophe', where their descriptions of experience are most intense; and Ryan's descriptions of feeling lost and not knowing what to do appear most heightened.

Additionally, participants' training and theoretical orientation may have played a part. Ryan's account stands out among other participants as he twice offered divergent opinions on a theme. He was the only one who reported fear of physical attack as a strong element of his experience, and reported feeling unable to establish a 'real' relationship with a person with schizophrenia. This, potentially, can be explained by his psychoanalytic training, which arguably promoted a more detached, blank-screen position in his therapeutic relationship with a client. James described his approach as CBT, and conveyed a rather 'rational' account of his experience (as compared to other participants). This difference might partially be the influence of his CBT training, which, on the whole, does not stress unconscious processes.

The above mentioned differences are just some of the possible explanations for the divergent experiences of the participants in this study. However, it is only possible to speculate as to this influence, rather than give a conclusive answer; therefore, the above considerations are offered tentatively.

It could be argued that the inclusion criteria were too broad. For example, restricting the inclusion criteria to only one type of clinical setting and one therapeutic modality may have reduced the variation in results. However, a more expansive approach would not have been practical due to the difficulty in finding sufficient numbers of participants. It can also be argued that the highlighted differences and contrasting experiences added richness to the data which may have otherwise been missed. Smith et al. (2009) suggest that homogeneity should be comparable with the amount of 'variation that can be contained within an analysis' (p. 49). In this study, arguably, participants' experiences regarding working with clients diagnosed with schizophrenia suggested that the diversity between their accounts was not problematic. Furthermore, remaining sensitive to the context of participants' experiences allowed additional containment of such diversity.

The use of semi-structured interviews represents a potential limitation; the researcher becomes the person in power by holding an agenda which might limit the interaction, steering it in a direction the participant might not have chosen otherwise (Potter & Hepburn, 2005). However, as discussed in the Methodology and Method chapters, the reflexive element was employed to minimise (although not eliminate) such impact. For further research a more 'naturalistic method' (Potter, 2002), for example a group discussion, could be used. However, it can be argued that research with fellow humans is always problematic in some way or another (West, 2013).

Another limitation concerns the subjective nature of the data collected and the researcher's interpretation of it. The data gathered reflect participants' experiences, understandings and beliefs, and are in no way attempting to claim 'historical truth' or represent an objective reality shared by all psychotherapists and counselling psychologists working with clients

diagnosed with schizophrenia. Instead, the purpose of this research was to immerse the reader in the interviewees' unique experiences of working with this client group.

This study does not assume universalisation of the experience of working with schizophrenia; it neither sets up an expectation that this is how therapists should experience their work, nor does it hope to provide an instruction of how to work with this client group. Such a manualised approach would have stripped the therapeutic experience of genuineness and sincerity, and would blind the therapist from seeing the individuality and uniqueness of the client he or she is working with. Assuming that we know about a particular client group and how we should work with them would hinder the practitioner's ability to connect with the client and be in touch with his or her own experiences, which ultimately are of utmost value in clinical work. In his book 'What is madness?' Leader (2011) notes that there is simply no formula for working with clients diagnosed with schizophrenia and psychosis. Despite the increasing modern pressure to pretend that there is one right way to do things, he reminds us that what happens in the relation between therapist and client has to be 'rethought and reinvented in each individual case' (p. 294).

Reflective considerations

It can be argued that the interviews were co-constructed; that is, they were a result of the interaction between the researcher and the participant. As suggested by Finlay (2009), "what is revealed emerges out of a constantly evolving, negotiated, dynamic, co-created relational process to which both researcher and participant co-researcher contribute" (p. 2). Therefore, it is important to provide some reflections on the interview process here.

As I interviewed fellow practitioners there was a level of understanding and familiarity based on theoretical knowledge and clinical experience which might have influenced my

assumptions about their experience. Thus, I had to remain aware of such assumptions throughout the interviews. One significant difference between participants and me was my status as a trainee, which might have influenced their responses. For example, they might have wanted to come across as competent practitioners who were confident in the work they were doing, and as a result more reluctant to discuss issues which they considered to demonstrate potential weakness. It is also possible that salient topics were omitted in the interests of privacy and confidentiality.

During the interviews I refrained from disclosing personal experiences around working with people diagnosed with schizophrenia in order to avoid influencing what emerged within the interviews. Despite this effort, my own subjectivity and professional interests might have impacted on the process of interviewing participants and analysing data. Denzin (1989) notes that the interpretation of participants' accounts is inevitably shaped by the researcher's own professional interests and subjectivity. My clinical interest in the psychodynamic model and the role of unconscious processes in therapeutic work might have given subtle clues to the participants to explore such processes in more detail during the interviews and is likely to have implicitly coloured the data analysis. However, as discussed in the methodology chapter, I was aware of this and deliberately avoided imposing my views during the interview process. While I stated my assumptions and expectations – and despite my best intention to 'put aside' my preconceptions and personal experiences with the client group concerned – the extent to which I may have influenced my listening and interpretation of the data is unknown.

Suggestions for further research

Certain limitations of this study, and some of the conclusions presented above, indicate possibilities for future research. The interviews were conducted with therapists only, and not with clients as well. In the master theme 'Symbiotic relationship' it was assumed that psychotherapy is beneficial for both clients and therapists. However, the client's perspective on the therapeutic value of psychotherapy was not included because this study focused exclusively on the therapist's experience. Thus, it could be argued that the findings do not represent a complete view of the therapeutic work and cannot be generalised to client's perceptions. It could be interesting in a different study to interview both clients and their therapists, which would potentially allow for deeper exploration around the dynamics in the therapy room.

Context could potentially be important in influencing how therapists experienced their work. For example, Melanie talked about not wanting to work in an inpatient mental hospital because the chaos of that environment felt too much for her, thus portraying this setting as disabling her in performing her role as a practitioner. Evelyn stated that she had consciously got out of the mental system, yet continued to work with people diagnosed with schizophrenia in her private practice. James, on the other hand, worked in a private hospital. The setting appears to have a significant impact on the practitioner; however, the data available in this study were insufficient to draw any conclusions about such impact. Future research into the differences between working in private practice, private and state hospitals and the therapeutic community may potentially add richness to the understanding of potential links between therapists' experience and the setting they work in.

In this study the focus was on therapists' experience of working with a group of clients diagnosed with schizophrenia. It is acknowledged, however, that within this broad

diagnostic category there are wide differences. These differences, potentially, have different impacts on the practitioner. For example, Evelyn noted that she often experienced feeling spaced out, 'off the ground', confused and aware of colours (see theme 'From confusion of minds to catastrophe'). However, she noted that such experiences were absent when working with clients' hallucinations (as opposed to clients who were thought disordered), concluding that hallucinations do not affect her thinking processes. Unfortunately, the data gathered are insufficient to speculate on a possible explanation, but this is a perplexing difference, nonetheless. Therefore, it could be of interest to explore in future research how particular symptoms impact on the therapist (such as clients in a catatonic state, or those experiencing hallucinations and delusions) and explore further the nature of such impact.

Another suggestion for future research is to investigate what psychological theories the practitioners find most useful in their work. Since the focus of this study was on participants' subjective experience, rather than their intellectual grasp of it, the researcher did not enquire further to what particular theories the participants considered most useful in their practice, but allowed them to refer to the theory that they specifically considered relevant to their experience.

Conclusion

This study has provided insight into psychotherapists' and counselling psychologists' subjective experience working with clients diagnosed with schizophrenia. The existing clinical literature in the field of psychotherapy highlights the challenges and the potential benefits of such work for the practitioner. It is evident that the diagnosis of schizophrenia rarely appears in the literature and research conducted in the field of counselling

psychology (Larsson, 2010). Current psychiatric understanding of schizophrenia points out to the biological basis of this condition, offering a predominantly chemical answer to the problem (Boyle, 2005). Despite this, participants in this study made sense of schizophrenia and worked with their clients in a relational way. Contrary to the currently dominant bio-medical understanding of schizophrenia, this research argues, based on the findings, for the need for psychotherapeutic treatment for people diagnosed with schizophrenia, with the focus on therapeutic relationship. Findings support the benefits of psychological treatments of schizophrenia. However, the clinical efficacy of psychotherapy for people diagnosed with schizophrenia was beyond the scope of the current study, thus no claims can be made in this regard.

The analysis resulted in twelve interrelated sub-themes, grouped into three master themes. The first theme, 'The dark territory', uncovered participants' common experience of this type of work as alien, utterly chaotic and confusing, which participants found alarming at the beginning of their career. The confusion of minds, psychotic communication and distorted perception acquired an almost mystical quality, presenting a challenge for the practitioner. The second master theme, 'Symbiotic relationship', revealed how emotionally involved the participants are with their clients, and that the therapeutic relationship in psychotherapy with people diagnosed with schizophrenia is mutually beneficial. Therapists' fascination with 'madness', mixed with their curiosity about the human mind and the desire to work through their own past experiences, showed the incentive of this type of work for the therapist. The final theme, 'Containment', exposed the emotional and practical needs of the practitioners in this field of work, including specialist supervision and additional training. The results indicate that training of counselling psychologists should address the complexities of working with clients diagnosed with schizophrenia to enable them to work effectively with this client group.

The findings also highlight that there is a need for specialist supervision to support practitioners coping with the demands posed by this client group.

Although one limitation of the method employed in this research is that it does not allow us to generalise from this small scale research, it offers an in-depth examination of the phenomena, which was the primary goal of this study. IPA recognises that access to experience is always dependent on what participants tell us about that experience, and that the researcher then needs to subjectively interpret that account in order to understand participants' experience (Smith et. al., 2009).

This research did not attempt to provide a comprehensive view of the topic, as this is inevitably beyond the scope of this study. It aimed to contribute to the literature on counselling psychology and schizophrenia by looking at therapists' subjective experience of working with clients diagnosed with schizophrenia, and to explore an area that is generally neglected in counselling psychology. This research is expected to be of value to any practitioner working with this client group, particularly helping those new to this field of work. It is hoped that this research will stimulate discussion amongst practitioners and normalise some of therapists' experiences of working with this client group. This study also hopes to encourage counselling psychologists to conduct further research on schizophrenia. In conclusion, this study posits that psychotherapy with clients diagnosed with schizophrenia is neither outdated nor inappropriate, but needs to be encouraged, despite the dominant medical paradigm of the present day.

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APPENDIX 1 – PARTICIPANT FACING MATERIALS

Information Sheet

Project title:

How psychotherapists and counselling psychologists experience working with clients diagnosed with schizophrenia: An interpretative phenomenological analysis

Purpose:

This study attempts to understand the subjective experiences of therapists working with clients diagnosed with schizophrenia. It might provide some insight into therapeutic practice and our understanding of the symptoms associated with this condition.

You will be asked about your understanding of schizophrenia and your thoughts and feelings associated with working with those clients. The aim of this study is to understand your subjective experience; its aspiration is to help all those involved in working with clients diagnosed with schizophrenia to cope with this category of clients.

Procedure:

If you agree to take part in this study, you will be asked to do the following:

(a) Read and sign the Participant Consent Form to say you agree to take part in this study (approximately 5 minutes)

(b) Have an in-depth semi-structured interview with the student researcher (Anna Gladoseva) on your experience of working with clients diagnosed with schizophrenia. This interview will be audio recorded and will last around 60 minutes.

(c) Finally, you will be debriefed by the researcher and will have an opportunity to ask questions (approximately 15 minutes).

Benefits and risks to the participant:

You may benefit in talking to someone else about your experiences and may learn something new about yourself. It is possible that it may lead you to re-evaluate your way of working with clients diagnosed with schizophrenia. You will be also directly

contributing to the psychological knowledge in the area of working with the severely mentally ill.

You may find the topic to be distressing or uncomfortable. Contact details of some support services will be provided for you after the interview.

Voluntary nature of the study and confidentiality:

Your participation in this study is completely voluntary and at any point you have the right to withdraw from the interview without giving an explanation. You also have the right to refuse to answer certain questions. You may stop at any time to ask the researcher any question you may have.

All your data from the research will be published anonymously. Your name will be changed into a pseudonym and only the researcher will know your personal identity.

You are welcome to refer to your client work if needed; however, please do NOT disclose anything to threaten the anonymity of your clients. If during the interview you mention any information which can identify your clients I will remind you to avoid such details.

If you are feeling uncomfortable with any part of the study after the interview, you still have the right to withdraw your data from the sample.

Contacts and questions:

This project has been approved under the procedures of the University of Roehampton's Ethics Committee and has raised no objections on ethical grounds. Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies):

Investigator:
Anna Gladoseva
Tel: 078 0787 3274
E-mail: gladosea@roehampton.ac.uk

Director of Studies Contact Details:
Dr. Janek Dubowski
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Head of Department Contact Details:
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University of Roehampton London

ETHICS COMMITTEE

Participant Consent Form

Title of Research Project: How psychotherapists and counselling psychologists experience working with clients diagnosed with schizophrenia: An interpretative phenomenological analysis

The purpose of this study is to explore how therapists experience working with clients diagnosed with schizophrenia. Participation will involve taking part in an interview, where you will be invited to share your experiences in as many details as possible. The interview will be held in a comfortable setting, which could be your own home and will take approximately an hour and a half. The interview will be audio-recorded for the purpose of the data analysis. All data from the research will be published anonymously. Your name will be changed into a pseudonym and only the researcher will know your personal identity. Please refer to the Information Sheet for further details.

Investigator Contact Details:

Name	Anna Gladoseva
Department	Psychology
Address	Whitelands College, Holybourne Avenue, London, SW15 4JD
Email	gladosea@roehampton.ac.uk
Telephone	078 078 732 74

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings.

I understand that there may be some instances in which the investigator is required to break confidentiality such as if there are concerns about a risk of serious harm to yourself or others.

Name …….....….

Signature …….....……

Date …….....…

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies).

Director of Studies Contact Details:

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University of Roehampton London

Debriefing Form

Research title: How psychotherapists and counselling psychologists experience working with clients diagnosed with schizophrenia: An interpretative phenomenological analysis.

Thank you for taking part in the present study. The aim of this study is to explore therapists' experience working with clients diagnosed with schizophrenia and the effects of the diagnosis and the concept of madness on their work. This study looks at potential difficulties and blocks to empathy when working with the severely mentally ill but might also be of potential benefits for the practitioner as well as the client.

It is acknowledged that it may be difficult to look at these kinds of aspects of your work and your generosity and willingness to discuss such topics is greatly appreciated. Your input will help to contribute to the advancement of knowledge in this field.

All data from the research will be published anonymously. Your name will be changed into a pseudonym and only the researcher will know your personal identity. Your consent form will be kept securely and separately from other data.

If you are feeling uncomfortable with any part of the study after the interview, you still have the right to withdraw your data from the sample.

You may find the subject matter uncomfortable to speak about. If at any time after the study you feel distressed and would like to speak to someone about your thoughts or feelings, please contact your supervisory support. If you feel that the support you received was insufficient you can contact any of the following counselling organisations:

Counselling services: Samaritans, 08457 909090, www.samaritans.org

Centre 70 Counselling,020 8670 2775, www.centre70.org.uk

Mind, 0300 123 3393, www.mind.org.uk

If you just have some general questions or if you would like any information about the results of the research feel free to contact the researcher or the director of studies.

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies):

Investigator:
Anna Gladoseva
Tel: 078 0787 3274
E-mail: gladosea@roehampton.ac.uk

Director of Studies Contact Details:
Dr. Janek Dubowski
Whitelands College
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Dr. Diane Bray
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Tel: 020 8392 3627
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Thank you for participating in this study.

Anna Gladoseva
Trainee Counselling Psychologist

APPENDIX 2 – PRELIMINARY LIST OF EMERGENT SUB-THEMES FOR EACH PARTICIPANT

Participant 1 - Ryan

Feeling lost

- Feeling lost in an alien territory
- Not knowing how to respond
- Giving oneself permission not to know
- Theory as a way of helping the practitioner to escape feelings of being lost and being unsure how to respond

Fear

- Fear as a strong element in the experience of interacting with people with psychosis
- Uncontained aggression
- Fear of the unpredictability of client's behaviour
- Fear in response to client's aggression
- Fear of verbal aggression and physical violence
- The role of neuroleptics in suppressing aggression
- Making sense of client's aggression in terms of psychoanalytic theory
- Fear of unpredictability of client's behaviour
- Engaging in practicalities as a way of dealing with one's fear

Repulsion

- Awareness of unpleasant smells and dishevelled appearance
- Being revolted
- Repulsiveness about clients' physicality

Pressure to know and produce an explanation

- Pressure
- Experiencing pressure to know it all (client's expectation that the therapist has an answer)

Being thrown by the unexpected response of a client

- Automatic or set ways of responding as unhelpful
- The difficulty of 'hearing' what is being said
- The challenge to respond in the moment without being caught up in the concrete or respond to the superficial meaning
- Joking as a way of pushing away what the client is bringing and dealing with one's anxiety
- "Falling into traps" – not knowing how to respond
- Influence of experience and frequency of working with clients with schizophrenia on therapist's ability to respond to client

Affection and Empathy

- Pleasure in giving an insight to a client that he/she can hold on to and make use of
- Affection
- Deep affection for the clients and their struggling
- Empathy
- Desire to help others originating in one's childhood experiences of pain
- Offering acceptance and compassion

Being bored by the clients

- Need to think extra hard
- Difficulty thinking extra hard and concentrating

Dissatisfaction in the relationship

- Limitations of psychosis: difficulty of forming a relationship
- Therapist's disappointment with what a relationship with a psychotic client can offer
- Lack of reciprocity in the relationship with a psychotic client
- Sense of oneself as being an object in the relationship

Therapist's motivation in working with this client group

- Understanding madness as a way of breaking limits which the participant can relate based on his own desire to break limits
- Working with clients as a way of increasing self-understanding

Understanding schizophrenia in psychoanalytic terms

- Influence of theoretical orientation
- Viewing delusions as a sustaining the client – critique of biomedical approach to symptom relief
- Importance of strengthening the client's ego to help them survive their fragility
- Strengthening client's ego as an objective of therapy
- Psychoanalytic theory for understanding schizophrenia
- Psychoanalytic understanding of schizophrenia

Therapy as no different from working with other clients

- Aspects of common experiences of therapeutic relationship - (normalising the experience)
- Intense relationship that stays with you
- Relaxed concentration as a general observation on working as a therapist
- The need to be authentic
- Ordinariness of the structure of schizophrenia

Defining 'mad'

- Difficulty in defining what is 'mad'
- 'Schizophrenia' and psychosis are used interchangeably
- Distinguishing 'wacky' from psychotic
- Familiarity versus alien experience

Participant 2 – David

Theoretical foundation / literature / influences on understanding schizophrenia

- The influence of literature (Shakespeare) on eliciting curiosity about and forming understanding of madness
- The influence of R.D.Lang
- The influence of C. Jung
- Influence of C Jung's ideas on understanding the symbolism of schizophrenia
- Influence of J. Janes work on understanding the 'normality' of psychotic experiences
- The importance of being theoretically grounded
- Psychosis and genius and creativity as close processes
- Throughout the narrative 'schizophrenia' and 'psychosis' are used interchangeably

Fascination

- Participant haunted by the concept of madness
- Fascination with 'the symbolism of schizophrenic discourse'
- Desire to work with the most disturbed clients
- Fascination with the madness

Empathy/fondness towards clients

- Fondness towards the patients
- Fondness towards an 'incurable' patient
- Enjoying work
- The reward of working with this field – illuminating discoveries about human psyche
- 'The dark territory'

Work process

- 'Stop being a hero' - the need to become disillusioned with one's ability to cure as a paradoxical way forward
- Therapist having an instinct for working with clients with schizophrenia
- Creative approach to engaging clients such as drama therapy

Patience

- Need to respect client's boundaries, limitations and difficulties
- Need for patience and allowing clients to open up with their own speed

Psychotic communication

- Dreams as psychotic communication
- Collective unconsciousness, noticing similarities between working with children and working with clients diagnosed with schizophrenia
- Psychotic communication: client's influence on therapist's dreams, phantasies and moods

Impact

- Impact of work on practitioner's objectivity
- Difficulty in understanding the metaphorical meaning and being caught in the concrete
- The power of projective identifications
- Joy in working with psychosis as a counterpart of the despair

Despair

- Despair as natural stage towards a way forward
- 'Going through hell'

Fear

- Fear of losing one's sanity as a result of dealing with primal processes of the client
- The importance of managing own reactions as a way of resisting the immense pressure on the integrity of practitioner's ego
- Staying balanced and in control as impossible endeavour when working with schizophrenia
- Feeling of overwhelming catastrophe
- The importance of allowing yourself to protect oneself, allowing yourself not to get it right
- Aggressive & violent behaviour of clients

The nature of work

- 'You're flying by the seat of your pants': The need to take authority and be humble
- Working with psychosis as 'ordinary' work of psychotherapists
- Ability of forming symbiotic connections as a critical pre-requisite of work in this area
- Using intuition in working with schizophrenia
- The need for temperament and gift to be able to survive working in this field
- Ability to manage own countertransference as an essential aspect of working with schizophrenia

- Belief in positive value of psychotherapy with psychosis

Supervision

- The importance of psychosis specific supervision

Participant 3 - Evelyn

Theory

- Role of theory in making sense of unconscious communications
- Throughout the narrative 'schizophrenia' and 'psychosis' are used interchangeably

Enjoying work

- Working with clients diagnosed with schizophrenia is the most stimulating work
- Intellectually and psychologically stimulating work
- Fascination with the work
- Enjoying the work
- Working with hallucinations is interesting
- Mentally stimulating work
- Promoting psychotherapy with schizophrenia
- Views research on schizophrenia as very important

Psychotic communication

- Psychotic processes - dreams
- Powerful unconscious communication with psychotic clients
- Ways of communicating with psychotic clients

Psychological danger

- Psychological threat
- Confusion
- Control over psychotic processes
- Impact on the cognitive processes of the therapist: altered state of perception, memory, understanding and reasoning
- An alarming experience of 'losing one's mind' characteristic of first years of working with psychotic clients
- Mastery over being in 'psychological danger' which comes with experience
- Impact on the therapist: total confusion and inability to stay with rational thought process
- Altered state of consciousness, un-articulable experience of confusion
- Split experience: rational and conscious, and emotional and experiential
- Confusion
- Therapist experiencing psychotic processes -altered state of consciousness

- Alterations in therapist's perceptions
- Spectrum of how a therapist experiences this work from being rational and grounded to being utterly confused as mimicking various degrees of 'madness'

Fear

- Fear of physical attack with the very first client
- Fear of mental attack was more characteristic of early career

Work process

- Flexibility and creativity to adopt to the needs of a floridly psychotic client
- Allowing yourself to following your instinct in the work
- There is no one standard experience typical of working with psychotic clients
- Suggestion of how to work with hallucinations: treating it as a straight episode
- Respecting the fragility of the client
- Use of humour in dealing with anxiety provoking situation
- Rationalisation as an unhelpful technique with client's symptoms
- Difficulty of thinking about limitations to work with clients with schizophrenia
- Risk (to self or others) as a limitation in working with schizophrenia
- Ways of managing risk issue in private practice
- Recovery as an objective of therapy
- Optimistic and confident position in her ability to help and ability of most clients to benefit from therapy

Ordinary work

- Working with client's hallucinations does not affect participant's thinking and is experienced as a 'normal' session
- Normalisation of working with clients diagnosed with schizophrenia

Empathy

- Compassion / deep empathy towards client's suffering or fear
- Empathy is crucial in this work
- Importance of establishing an emotional connection, allowing to be affected by client's distress as a way of relating
- Feeling in control while her perceptions are impaired as empathy serves as an anchor to the therapist's reality
- Empathic response to client's heart-breaking suffering

- Self-harm in working with schizophrenia elicits empathy in the therapist whereas with non-psychotic clients it alienates the therapist
- Affection and fondness towards the client

Mental health system

- Disappointment with the mental health system
- Criticism of medical model for pathologising clients

Therapist's motivation

- Impact of personal life history of the therapist on her work
- Need to master past trauma and sense of helplessness as a motivating force in desire to help clients in the present
- Mastery over helplessness
- Drawn to working with schizophrenia and fascinated by it

Demanding client group

- 'Taking clients home'
- Need for grounding: Importance of schizophrenia specific supervision
- Need for grounding: Importance of theory
- Work is described as 'utter unbridle chaos'

Practical issues

- Practical difficulties in working with schizophrenia in private practice:
- Lack training on psychosis
- Client's low income as a practical difficulty in private practice

Participant 4 - James

Fascination

- Fascination with the disorder and with the people who suffer from it
- Fascination with mental hospital environment – 'parallel world'

Enjoyment

- Fulfilling work
- People diagnosed with schizophrenia are hardworking clients
- Enjoyment in finding meaning together
- Rewarding experience

Sense of emotional closeness with the client

- Importance of building a relationship
- Establishing an emotional connection
- Sense of closeness as the main characteristic of the experience

Sensitivity

- Fascination with the sensitivity and vulnerability of this client group
- Empathy

Process of therapy

- Meaning making process as a crucial part of therapy
- Working at a slower pace as a way of protecting client's self esteem
- The need to creatively adjust techniques to client's vulnerability and limitations
- Targeting compliance issues
- Empowering clients to address their needs with their consultant
- Importance of working with clients' difficulties such as shame
- Importance of empowering the client
- Importance of working with clients' difficulties such as loneliness
- Absence of fear

Protectiveness

- Respect for vulnerability – desire to protect the clients from being shamed
- Desire to rescue as a response to client's vulnerability

- Parental role looking after the clients
- Providing extra care
- Danger of overprotecting
- Finding balance between 'extra care' and not overprotecting

View of recovery

- Confidence in curative potential of psychotherapy with schizophrenia
- Struggling to see limitations
- Being realistic - Cure versus recovery
- The need for therapist to accept that not all clients can lead a symptom free life
- The need for the therapist to be patient
- Acceptance and finding meaning as a realistic goal of therapy
- Confident & enthusiastic about the value of psychotherapy

Training and influence

- Training message: infantilising the client
- Limitations of the training
- The differences of CBT practice in Germany and the UK
- Influence of R.D. Laing on understanding schizophrenia
- Support and influence of colleagues on one's work

Understanding of schizophrenia

- View of 'Madness' as derogatory word
- The importance of finding meaning of hallucinations given client's history
- Understanding schizophrenia as different from madness
- Training organisation communicating being cautious with clients with schizophrenia
- Societal stigma
- Public perception of threat
- Absence of physical threat (apart from one off example)
- Therapists' fear of clients diagnosed with schizophrenia
- Understanding the symptoms of schizophrenia as ordinary experiences of higher intensity

Motivation for working with clients with schizophrenia

- Promoting work with clients diagnosed with schizophrenia

- Stigma among psychotherapists
- Sense of neglect of this client group in psychotherapy
- Sense of a shared experience with the client as a motivation to work with his client group
- Importance of therapist's experiences and biography in attracting a therapist to this client group
- Clients' sensitivity is valuable for the participant
- Kindness and responsiveness of people with schizophrenia as an attractive quality
- Finding people with schizophrenia very interesting
- Sense of connection and closeness as a motivational factor
- Clients' ability to establish trust as a rewarding aspect of work

Therapists managing their work

- Importance of supervision with a practitioner experienced in the field of schizophrenia and psychosis
- Importance of learning about schizophrenia

Participant 5 - Emma

Medical model versus psychotherapy

- Negative view of the medical model
- Participant's own experience of being diagnosed with depression
- Limitations and disapproval of the medical approach
- Criticism of the medical model
- Criticisms of the use of drugs
- Psychotherapy as a healing journey
- Participant's view of psychotherapy
- Anger towards the imperfect/limited structure/ medical model

Diagnosis

- The impact of the diagnosis on practitioner's expectations
- Inaccurate diagnosis as stigmatising /limitations of the diagnosis when schizophrenia gets mixed up with antisocial behaviour
- View of the diagnosis as negative and unhelpful

Schizophrenia as a normal experience

- Normalising client's experience of schizophrenia
- Participant's need to normalise the experience of schizophrenia as a way of rescuing a client
- Experiencing her client as different from a common stereotypical view of a person with schizophrenia – normalising the experience of schizophrenia
- Colluding with the client in normalising the experience of schizophrenia

Schizophrenia is an alien experience

- Need to bracket off one's view on diagnosis
- Staying with client's experience as challenging
- Difficulty to stay with the experience of the client
- Psychotic episode as dramatically shifting participant's experience of the client
- Inexplicable difference in the relationship in the lead up to psychotic episode
- Schizophrenia is an alien experience
- Misunderstanding (Client and therapist as two different realities)

Desire to rescue a client

- Client's anger projected onto therapist
- Importance of experience on the ability to tolerate the feeling of being lost
- 'Taking client home'
- Questioning one's views

Need for grounding and support

- Role of theory in helping the participant to tolerate the experience by trying to make sense of it
- Psychosocial understanding of the causes of schizophrenia
- Protective role of theory
- Influence of R.D.Laing

Experiencing anxiety in the room

- Experiencing anxiety
- Inability to communicate with a shut off part of the client
- Rescuing as an attempt to deal with the anxiety
- Difficulty in talking on feelings and responses to the client

Need to manage powerful emotions

- Staying with the phenomena as a way of working
- Need to bracket off one's feelings

Sadness for people diagnosed with schizophrenia

- Feeling protective towards severely mentally ill
- Disappointment with current mental health system and lack of resources
- Sadness as a response to hopelessness about current options for people with schizophrenia
- Compassion
- Hopelessness about the future of people diagnosed with schizophrenia
- Sadness about most people's inability to access help

Understanding schizophrenia

- Risk of going mad as a normal phenomena
- Family dynamics as a cause of vulnerability to madness

Training difficulties

- Lack of psychiatric placements during psychotherapy training
- Private practice as a hurdle in the work with schizophrenia

Participant 6 - Melanie

Challenging client group

- The impact on the family
- Need for joined help process in terms of a setting for therapeutic work
- Limitation of private practice as a setting in terms of offering the support the client needs
- Challenging client group
- Steep learning curve
- Schizophrenia as chaos
- Need to contain and limitations of such containment when a client is experiencing psychotic symptoms

Altered state of perceptions

- Being aware of one's thought processes
- Disorientation
- 'Being in slight parallel universe'
- 'Spaced out'
- Altered state of perceptions explained as countertransference

Fear

- Fear during initial meeting
- Not knowing what to expect as a frightening experience
- Feeling lost and not knowing what to do
- Spending time with a psychotic person makes one challenge one's sanity
- Fear in general public
- Initial fear of clients before establishing a relationship with them
- Fear of violence as opposed to fear of clients diagnosed with schizophrenia

Impact of lack of self-care

- Repulsion as limiting therapist ability to 'see the person underneath'

Importance of an accepting relationship

- Importance of taking thorough client history
- Importance of establishing an emotional connection with the client
- Importance of an accepting relationship

- In light of mistreatment in the medical system there is a huge need to be human with this client group
- The need for sensitivity around schizophrenia
- Subjective experience as a way of understanding schizophrenia
- 'It's all about finding a way in'
- Establishing a connection with the client rather than treating the symptoms
- Relationship with the therapist as a healing component
- Curiosity and wanting to know clients story
- Viewing relational approach to therapy as more beneficial to the client than CBT
- Sitting with the unknown as a way of working with this client group
- Separating one's reality as a way of establishing connection with a client
- Understanding and accepting client's reality as a way of strengthening the relationship

Intensity and chaos

- The prospect of working solely with clients diagnosed with schizophrenia in an inpatient hospital setting feels intense and 'too much'
- Chaos is unbearable
- Lack of steady progress as a challenging aspect of work
- 'Symptoms are getting in the way'

Criticisms of the medical approach to treatment

- Anger about psychiatric approach to dealing with clients
- Biomedical model's limitation in explaining the experience of schizophrenia
- Medical versus existential view
- Schizophrenia as the unknown and limitations of intellectual understanding
- Making sense of the symptoms by acknowledging client's reality as different
- Holistic approach to treatment as a healing component (opposed to medical model)

Schizophrenia as an alien experience

- Need to step out of one's reality in order to empathise with the client
- Schizophrenia as an alien experience
- Schizophrenia as the unknown
- Use of labels as an attempt to capture an experience that is difficult to capture

Powerlessness and desire to help

- Powerlessness and not being able to make it better for the client

- Desire to help (protectiveness)
- Desire to help as response to sensing person's vulnerability
- Powerlessness
- Affection

APPENDIX 3 – TABLE OF ALL EMERGENT THEMES

This visual chart was used to identify emerging sub-themes, similarities and differences between the participants.

Ryan	David	Evelyn	James	Emma	Melanie
▪ Throughout the narrative schizophrenia, psychosis and madness are used interchangeably ▪ Difficulty in defining what is 'mad' ▪ Feeling lost ▪ Familiarity versus alien experience ▪ Distinguishing 'wacky' from psychotic ▪ Feeling lost in an alien territory ▪ 'Schizophrenia' and psychosis are used interchangeably ▪ Fear as a strong element in the experience of interacting with people with psychosis ▪ Uncontained aggression ▪ Fear of the unpredictability of client's behaviour ▪ Awareness of unpleasant smells and dishevelled appearance ▪ Fear in response to client's aggression ▪ Fear of unpredictability of client's behaviour ▪ Fear of verbal aggression and physical violence ▪ The role of neuroleptics in suppressing aggression ▪ Making sense of client's aggression in terms of psychoanalytic theory ▪ Influence of theoretical orientation ▪ Being revolted ▪ Repulsiveness about clients' physicality	▪ Throughout the narrative 'schizophrenia' and 'psychosis' are used interchangeably ▪ Participant haunted by the concept of madness ▪ The influence of literature (Shakespeare) on eliciting curiosity about and forming understanding of madness ▪ The influence of R.D. Lang ▪ The influence of C. Jung ▪ Fascination with 'the symbolism of schizophrenic discourse' ▪ Desire to work with the most disturbed clients ▪ Fondness towards the patients ▪ Belief in positive value of psychotherapy with psychosis ▪ Fondness towards an 'incurable' patient ▪ Need to respect client's boundaries, limitations and difficulties ▪ Aggressive & violent behaviour of clients ▪ Need for patience and allowing clients to open up with their own speed ▪ Influence of C Jung's ideas on understanding the symbolism of schizophrenia ▪ Therapist having an instinct for working with clients with schizophrenia ▪ Creative approach to engaging clients such as drama therapy ▪ Dreams as psychotic	▪ Throughout the narrative 'schizophrenia' and 'psychosis' are used interchangeably ▪ Enjoying work ▪ Working with clients diagnosed with schizophrenia is the most stimulating work ▪ Intellectually and psychologically stimulating work ▪ 'Taking clients home' ▪ Psychotic processes - dreams ▪ Powerful unconscious communication with psychotic clients ▪ Feeling empathic towards client's traumatic experiences ▪ Ways of communicating with psychotic clients ▪ Role of theory in making sense of unconscious communications - theory ▪ Experience that comes with time; terrifying at the begging ▪ Fear of physical attack with the very first client ▪ Fear of physical attack characteristic of early career ▪ Psychological threat ▪ Confusion ▪ Control over psychotic processes ▪ Impact on the cognitive processes of the therapist: altered state of perception, memory, understanding and reasoning ▪ An alarming experience of 'losing	▪ Fascination with the disorder and with the people who suffer from it ▪ Influence of R.D. Laing on understanding schizophrenia ▪ Fascination with the sensitivity and vulnerability of this client group ▪ Respect for vulnerability – desire to protect the clients from being shamed ▪ Fulfilling work ▪ People diagnosed with schizophrenia are hardworking clients ▪ Meaning making process as a crucial part of therapy ▪ Empathy ▪ Enjoyment in finding meaning together ▪ Rewarding experience ▪ Desire to rescue as a response to client's vulnerability ▪ Protectiveness as a response to client's vulnerability ▪ Working at a slower pace as a way of protecting client's self esteem ▪ Parental role looking after the clients ▪ Providing extra care ▪ Finding balance between 'extra care' and not overprotecting ▪ Limitations of the training ▪ Training message: infantilising the client ▪ Protectiveness	▪ Negative view of the medical model ▪ Participant's own experience of being diagnosed with depression ▪ Need to bracket off one's view on diagnosis ▪ View of the diagnosis as negative and unhelpful ▪ Normalising client's experience of schizophrenia ▪ Participant's need to normalise the experience of schizophrenia as a way of rescuing a client ▪ Staying with client's experience as challenging ▪ Desire to rescue a client ▪ Difficulty to stay with the experience of the client ▪ Experiencing her client as different from a common stereotypical view of a person with schizophrenia – normalising the experience of schizophrenia ▪ Psychotic episode as dramatically shifting participant's experience of the client and the relationship between them ▪ Client's anger projected onto therapist ▪ Misunderstanding (Client and therapist as two different realities) ▪ Importance of experience on the ability to tolerate the feeling of being lost ▪ 'Taking client home' ▪ Questioning one's views	▪ Steep learning curve ▪ Challenging client group ▪ Steep learning curve ▪ Being aware of one's thought processes ▪ Impact of lack of self-care ▪ Fear during initial meeting ▪ Not knowing what to expect as a frightening experience ▪ Relationship with the therapist as a healing component ▪ Separating one's reality as a way of establishing connection with a client ▪ Disorientation ▪ Personal challenge for the therapist in how to respond to the differences in perceiving reality ▪ Understanding and accepting client's reality as a way of strengthening the relationship ▪ Feeling lost and not knowing what to do ▪ Fear ▪ Anger about psychiatric approach to dealing with clients ▪ Limitations of therapy ▪ Need to contain and limitations of such containment when a client is experiencing psychotic symptoms ▪ Making sense of the symptoms by acknowledging client's reality as different ▪ Affection

▪ Experiencing pressure to know it all (client's expectation that the therapist has an answer) ▪ Feeling lost and not knowing how to respond ▪ Pressure to know and produce an explanation ▪ Giving oneself permission not to know ▪ Not knowing how to respond ▪ Automatic or set ways of responding as unhelpful ▪ The difficulty of hearing what is being said ▪ Being thrown by the unexpected response of a client ▪ The challenge to respond in the moment without being caught up in the concrete or respond to the superficial meaning ▪ Joking as a way of pushing away what the client is bringing and dealing with one's anxiety ▪ "Falling into traps" – not knowing how to respond ▪ Influence of experience and frequency of working with clients with schizophrenia on therapist's ability to respond to client ▪ Affection ▪ Pleasure in giving an insight to a client that he/she can hold on to and make use of ▪ Affection ▪ Aspects of common experiences of therapeutic relationship - (normalising the experience) ▪ Intense relationship that stays with you ▪ Deep affection for the clients and their struggling ▪ Being bored by the clients ▪ Need to think extra hard	communication ▪ Collective unconsciousness, noticing similarities between working with children and working with clients diagnosed with schizophrenia ▪ Difficulty in understanding the metaphorical meaning and being caught in the concrete ▪ Impact of work on practitioner's objectivity ▪ Fear of losing one's sanity as a result of dealing with primal processes of the client ▪ The importance of managing own reactions as a way of resisting the immense pressure on the integrity of practitioner's ego ▪ The power of projective identifications ▪ Influence of J. Janes' work on understanding the 'normality' of psychotic experiences ▪ Staying balanced and in control as impossible endeavour when working with schizophrenia ▪ Feeling of overwhelming catastrophe ▪ The importance of allowing yourself to protect oneself, allowing yourself not to get it right ▪ 'You're flying by the seat of your pants': The need to take authority and be humble ▪ Psychotic communication: client's influence on therapist's dreams, phantasies and moods ▪ Fascination with the madness ▪ Psychosis and genius and creativity as close processes ▪ 'The dark territory' ▪ Working with psychosis as 'ordinary' work of psychotherapists ▪ 'Stop being a hero' - the need to	one's mind' characteristic of first years of working with psychotic clients ▪ Mastery over being in 'psychological danger' which comes with experience ▪ Enjoyment and fascination with the work ▪ Impact on the therapist: total confusion and inability to stay with rational thought process ▪ Altered state of consciousness, un-articulable experience of confusion ▪ Split experience: rational and conscious, and emotional and experiential ▪ Confusion ▪ Flexibility and creativity to adopt to the needs of a floridly psychotic client ▪ Allowing yourself to following your instinct in the work ▪ There is no one standard experience typical of working with psychotic clients ▪ Working with client's hallucinations does not affect participants thinking and is experienced as a 'normal' session ▪ Normalisation of working with clients diagnosed with schizophrenia ▪ Use of humour in dealing with anxiety provoking situation ▪ Respecting the fragility of the client ▪ Normalisation of working with clients diagnosed with schizophrenia ▪ Working with hallucinations is interesting ▪ Mentally stimulating work ▪ Compassion / deep empathy towards client's suffering or fear	▪ Danger of overprotecting ▪ The need to creatively adjust techniques to client's vulnerability and limitations ▪ Targeting compliance issues ▪ Empowering clients to address their needs with their consultant ▪ Caring and protective towards clients ▪ Confidence in curative potential of psychotherapy with schizophrenia ▪ Struggling to see limitations ▪ Being realistic - Cure versus recovery ▪ The need for therapist to accept that not all clients can lead a symptom free life ▪ The need for the therapist to be patient ▪ Acceptance and finding meaning as a realistic goal of therapy ▪ The differences of CBT practice in Germany and the UK ▪ The need for realistic expectations ▪ View of 'Madness' as derogatory word ▪ The importance of finding meaning of hallucinations given client's history ▪ Understanding schizophrenia as different from madness ▪ Training organisation communicates being cautious with clients diagnosed with schizophrenia ▪ Acknowledging the fear of schizophrenia in the public ▪ Societal stigma ▪ Public perception of threat ▪ Absence of physical threat (apart from a one off example) ▪ Therapists' fear of clients	▪ Role of theory in helping the participant to tolerate the experience by trying to make sense of it ▪ Psychosocial understanding of the causes of schizophrenia ▪ Protective role of theory ▪ Experiencing anxiety ▪ Colluding with the client in normalising the experience of schizophrenia ▪ Inability to communicate with a shut off part of the client ▪ Inexplicable difference in the relationship in the lead up to psychotic episode ▪ Experiencing anxiety ▪ Schizophrenia is an alien experience ▪ Limitations and disapproval of the medical approach ▪ Influence of R.D. Laing ▪ Staying with the phenomena as a way of working ▪ Need to bracket off one's feelings ▪ Rescuing as an attempt to deal with the anxiety ▪ Sadness for people diagnosed with schizophrenia ▪ Criticism of the medical model ▪ Feeling protective towards severely mentally ill ▪ Disappointment with the current mental health system and lack of resources ▪ Sadness as a response to hopelessness about current options for people with schizophrenia ▪ Anger towards the imperfect/limited structure/ medical model ▪ Compassion	▪ Holistic approach to treatment as a healing component (opposed to medical model) ▪ Altered state of perceptions explained as countertransference ▪ Need to step out of one's reality in order to empathise with the client ▪ Schizophrenia as an alien experience ▪ Viewing Relational approach to therapy as more beneficial to the client than CBT ▪ Spending time with a psychotic person makes one challenge one's sanity ▪ Powerlessness and not being able to make it better for the client ▪ 'Being in slight parallel universe' ▪ 'Spaced out' ▪ Desire to help (protectiveness) ▪ Desire to help as response to sensing person's vulnerability ▪ Powerlessness ▪ Lack of steady progress as a challenging aspect of work ▪ Curiosity and wanting to know clients story ▪ 'Symptoms are getting in the way' ▪ Repulsion as limiting therapist ability to 'see the person underneath' ▪ Biomedical model's limitation in explaining the experience of schizophrenia ▪ Schizophrenia as an alien experience ▪ Medical versus existential view ▪ Schizophrenia as the unknown and limitations of intellectual understanding ▪ Sitting with the unknown as a way of working with this client group

▪ Difficulty thinking extra hard and concentrating ▪ Relaxed concentration as a general observation on working as a therapist ▪ Theory as a way of helping the practitioner to escape feelings of being lost and being unsure how to respond ▪ Engaging in practicalities as a way of dealing with one's fear ▪ The need to be authentic ▪ Viewing delusions as sustaining the client – critique of biomedical approach to symptom relief ▪ Importance of strengthening the client's ego to help them survive their fragility ▪ Strengthening client's ego as an objective of therapy ▪ Psychoanalytic theory for understanding schizophrenia ▪ Psychoanalytic understanding of schizophrenia ▪ Limitations of psychosis: difficulty of forming a relationship ▪ Therapist's disappointment with what a relationship with a psychotic client can offer ▪ Lack of reciprocity in the relationship with a psychotic client ▪ Dissatisfaction in the relationship ▪ Sense of oneself as being an object in the relationship ▪ Offering acceptance and compassion ▪ Understanding madness as a way of breaking limits which the participant can relate to, based on his own desire to break limits ▪ Ordinariness of the structure of schizophrenia ▪ Working with clients as a way of increasing self-understanding	become disillusioned with one's ability to cure as a paradoxical way forward ▪ Despair as natural stage towards a way forward ▪ Joy in working with psychosis as a counterpart of the despair ▪ The need for temperament and gift to be able to survive working in this field ▪ 'Going through hell' ▪ The reward of working with this field – illuminating discoveries about human psyche. ▪ Ability to manage own countertransference as an essential aspect of working with schizophrenia ▪ The importance of being theoretically grounded ▪ The importance of psychosis specific supervision ▪ Ability of forming symbiotic connections as a critical pre-requisite of work in this area ▪ Using intuition in working with schizophrenia	▪ Rationalisation as an unhelpful technique ▪ Empathy is crucial in this work ▪ Importance of establishing an emotional connection, allowing to be affected by client's distress as a way of relating ▪ Spectrum of how a therapist experiences this work from being rational and grounded to being utterly confused as mimicking various degrees of 'madness' ▪ Therapist experiencing psychotic processes such as an altered state of consciousness ▪ Alterations in therapist's perceptions ▪ Feeling in control while her perceptions are impaired as empathy serves as an anchor to therapist's reality ▪ Empathic response to client's heart-breaking suffering ▪ Self-harm in working with schizophrenia elicits empathy in the therapist whereas with non-psychotic clients it alienates the therapist ▪ Difficulty of thinking about limitations to work with clients with schizophrenia ▪ Risk (to self or others) as a limitation in working with schizophrenia ▪ Ways of managing risk issue in private practice ▪ Recovery as an objective of therapy ▪ Optimistic and confident position in her ability to help and ability of most clients to benefit from therapy ▪ Impact of personal life history of the therapist on her work ▪ Disappointment with the mental health system	diagnosed with schizophrenia ▪ Confident & enthusiastic about the value of psychotherapy ▪ Support and influence of colleagues on one's work ▪ Sense of a shared experience with the client as a motivation to work with his client group ▪ Importance of therapist's experiences and biography in attracting a therapist to this client group ▪ Clients' sensitivity is valuable for the participant ▪ Understanding the symptoms of schizophrenia as ordinary experiences of higher intensity ▪ Fascination with mental hospital environment – 'parallel world' ▪ Kindness and responsiveness of people with schizophrenia as an attractive quality ▪ Finding people with schizophrenia very interesting ▪ Sense of connection and closeness as a motivational factor ▪ Clients' ability to establish trust as a rewarding aspect of work ▪ Importance of supervision with a practitioner experienced in the field of schizophrenia and psychosis ▪ Importance of learning about schizophrenia ▪ Importance of working with clients' difficulties such as shame ▪ Importance of empowering the client ▪ Importance of working with clients' difficulties such as loneliness ▪ Absence of fear ▪ Grounded in his perceptions and sense of self	▪ Hopelessness about the future of people diagnosed with schizophrenia ▪ Sadness about most people's inability to access help ▪ Lack of psychiatric placements during psychotherapy training ▪ Inaccurate diagnosis as stigmatising /limitations of the diagnosis when schizophrenia gets mixed up with antisocial behaviour ▪ The impact of the diagnosis on practitioner's expectations ▪ Risk of going mad as a normal phenomena ▪ Family dynamics as a cause of vulnerability to madness ▪ Private practice as a hurdle in the work with schizophrenia ▪ Criticisms of the use of drugs ▪ Criticisms of the medical model ▪ Psychotherapy as a healing journey ▪ Participant's view of psychotherapy ▪ Difficulty in talking about the feelings and responses to the client	▪ Schizophrenia as an alien experience ▪ Schizophrenia as chaos ▪ 'It's all about finding a way in' ▪ Establishing a connection with the client rather than treating the symptoms ▪ Fear in general public ▪ Initial fear of clients before establishing a relationship with them ▪ Fear of violence as opposed to fear of clients diagnosed with schizophrenia ▪ Limitation of private practice as a setting in terms of offering the support the client needs ▪ Need for joined help process in terms of setting for therapeutic work ▪ Importance of taking a thorough client history ▪ Importance of establishing an emotional connection with the client ▪ In light of mistreatment in the medical system there is a huge need to be human with this client group ▪ Importance of an accepting relationship ▪ The need for sensitivity around schizophrenia ▪ Subjective experience as a way of understanding schizophrenia ▪ The impact on the family ▪ The prospect of working solely with clients diagnosed with schizophrenia in an inpatient hospital setting feels intense and 'too much' ▪ Chaos is unbearable ▪ Schizophrenia as the unknown ▪ Use of labels as an attempt to

▪ Empathy ▪ Desire to help others originating in one's childhood experiences of pain		▪ Need to master past trauma and sense of helplessness as a motivating force in desire to help clients in the present ▪ Mastery over helplessness ▪ Enjoying the work ▪ Affection and fondness towards the client ▪ Drawn to working with schizophrenia and fascinated by it ▪ Normalising work with schizophrenia and client's experiences ▪ Criticism of medical model for pathologising clients ▪ Need for grounding: Importance of schizophrenia specific supervision ▪ Need for grounding: Importance of theory ▪ Work is described as 'utter unbridle chaos' ▪ Promoting psychotherapy with schizophrenia ▪ Practical difficulties in working with schizophrenia in private practice: ▪ Lack of training on psychosis ▪ Client's low income as a practical difficulty in private practice ▪ Views research on schizophrenia as very important	▪ Empathy ▪ Realistic view of the progress in psychotherapy ▪ Empathy ▪ Sense of closeness as the main characteristic of the experience ▪ Promoting work with clients diagnosed with schizophrenia ▪ Stigma among psychotherapists ▪ Sense of neglect of this client group in psychotherapy ▪ Importance of building a relationship ▪ Establishing an emotional connection		capture an experience that is difficult to capture

APPENDIX 4: TABLE OF THEME PREVALENCE AND EXTRACT SELECTION

Themes	Prevalence of theme (number of participnats represent in theme)	Extracts provided in support of theme
'THE DARK TERRITORY'		
'You're flying by the seat of your pants'	5	Evelyn Melanie Ryan David
'Something familiar ... but on the other hand ... completely alien'	5	David Evelyn Melanie Ryan Emma
From confusion of minds to catastrophe	4	Melanie Evelyn David
Fear	5	Ryan Melanie Evelyn James
SYMBIOTIC RELATIONSHIP		
Fascination	4	David Evelyn James Melanie
Affection, empathy and Protectiveness	6	Ryan Evelyn James Emma Melanie
The importance of the relationship	5	Melanie Emma Ryan James
Personal history as therapist's motivation	4	Ryan

		Evelyn James
Benefits of psychotherapy for clients	6	Evelyn James
CONTAINMENT		
The role of theory in trying to make sense of schizophrenia	5	Evelyn David Emma Ryan Melanie
Containment through supervision	5	Evelyn James David
The abandoned client group: need for training	4	James Evelyn Emma

APPENDIX 5 – DRAFT INTERVIEW SCHEDULE USED FOR THE PILOT INTERVIEW

1) Can you tell me about your experience of working with clients diagnosed with schizophrenia?

2) What role, if any, does anger, fear and/or frustration play in your work with clients diagnosed with schizophrenia?

4) Is therapy with this client group beneficial?

3) How do you understand ‘madness’?

APPENDIX 6 – ANALYSIS OF THE INTERVIEW TRANSCRIPTS

For ease of reference page numbers in this Appendix 6 will be numbered separately, starting with page 1 for each individual interview.

PARTICIPANT 1 – RYAN
Interpretative Phenomenological Analysis of the interview transcript

R: Text – stands for researcher's interventions
Bold – Notable quotes, used in the results section for illustration of the themes
Exploratory comments: Descriptive comments (normal text), Linguistic comments (*italic*), Conceptual comments (<u>underlined</u>)
Square brackets and italic within the transcript – descriptions of non-verbal communication and background sounds

Emergent themes	Original transcript	Exploratory comments
	R: I don't have too many questions; it's basically for you to just tell me about your experience, what was it like for you in the room with someone with schizophrenia?	
Difficulty in defining what is 'mad' Feeling lost	That's a very open question, it is kind of difficult [*R: You can free associate*] yeah? I'll have to try and do that. Amm, well, the first thing that comes to my mind is amm, perhaps because we were talking about the religious thing, one of the first people I saw when I went into therapeutic community and was asked to, you know, see individual patients, was a chap with very florid religious delusions and I didn't know how to respond and I was thinking all the time 'how is this', it was, he was obviously mad and I, I, but 'I thought how do I know this is mad?' Amm, how is it different from what I believe, or used to believe, probably still believe or what the other monks or my family believed and so on. Amm, and so the, the experience, the subjective experience was very much one being lost, really, feeling that something, **having the impression that something was** familiar you know he was talking about the virgin and some catholic images,	(Refers to a short introductory conversation that we had before the interview. Before training as a psychotherapist this participant was a priest and recently published a book on religion and madness) Difficulty to distinguish 'normal' from 'abnormal', the fine line separating sanity and insanity. Feeling lost

Emergent themes	Original transcript	Exploratory comments
Familiarity versus alien experience Distinguishing 'wacky' from psychotic Feeling lost in an alien	myths or ideas like that. So something **familiar but on the other hand it had an obvious twist which made it completely alien and unfamiliar and seemed completely mad**. Just to, difficult, you said free association, remembering now living in a house probably 20 years ago, moving to a house and the, there is a little garden and there's joined other garden either side and we got sort of on friendly terms with people on the other side and there was an elderly couple on one side and they were sort of born again Christians you know, Protestant and [*inaudible*] or something like that and they used to say things like you know if you started talking to me 'oh, I'm having difficult time at work' or you know, whatever, they would say things like you know 'have a word with Jesus, you know, he will sort it out for you or something like that. As if it was something like you know pick up the phone and call God kind of thing and I used to say to [*name of his wife*][1], my wife, I used to say 'obviously they are really mad'. Ok, they weren't suffering from psychosis amm, but in relation, in comparison with the religious group I've been with they seemed pretty wacky and yet they obviously didn't have psychosis so am, you know, there was another sort of distinction coming in there for me in my mind, so when I am thinking about the chap with psychosis, it wasn't just that he had nutty religious beliefs which I could find with our neighbours in other words, beliefs bore no relation to my experience or, or, religious beliefs amm, it was something else, something different and that feeling of one being lost. So that's the first thing I'd say is the **sense of being lost in an alien territory**	Familiar and simultaneously completely alien The twisting of the familiar seems mad <u>Gestalt/picture and background 'seeing it one second and not seeing it a moment later', similar to his description of seeing something as 'normal' and then not</u> Compares somebody who is 'pretty wacky' with somebody with psychosis Unusual beliefs are insufficient for somebody to be defined as psychotic

[1] Names, mentioned in the interview, were deleted to preserve participant's anonymity

Emergent themes	Original transcript	Exploratory comments
territory	**where there's some, something missing in the communication** amm and you didn't want me to say anything about, I think, about theory, hmm, because I could talk to you why I think that is	Feeling lost in an alien territory signifies for the participant that a person is psychotic
	R: You can if you want to	
	may not be so relevant, well, what I'd say is that, the nutty neighbours sound nutty because amm, their discourse is one which is specific to a group which I don't belong to, so they have a way of speaking and a way of thinking which is alien to me, I'm an outsider, it's a bit like foreign language. Whereas with the chap with psychosis it's not really a language because it's not shared, other, other people with psychosis don't agree with him, they don't agree with the way in which he, he names, he names things so, amm, you, you don't, you don't, whereas you have the group of religious believers that all amm, accept and agree on the meaning and definition of terms and believe certain myths, they hold those in common, you don't get that with a group of psychosis, with people with psychosis, it's an individualised use of language and so basically that's how I see it as different although they, as in the case of this chap we talked about the Virgin and so on, they, they often take names and concepts or figures, people, saints or Christ or whatever, they take them from other religious discourses and make those people or those ideas elements in their own system, it's their own individual system, it's not that they are inserted into a common system. So in that sense it's not a language, because for language you need an agreement on terms, sharing community So,	Explains how he makes a distinction between psychotic discourse from a non-psychotic one: psychotic discourse implies an individualised use of language where there is no agreement on terms shared by a community

Emergent themes	Original transcript	Exploratory comments
'Schizophrenia' and psychosis are used interchangeably Fear as a strong element in the experience of interacting with people with psychosis Uncontained aggression Fear of the unpredictability of client's behaviour	the, the point I was making there was initially, my first experience I think was being lost. **Another strong element in the experience of interacting with people with psychosis is fear**. **Often I'd experienced the edge, a violent edge** or an, ammm, **something uncontained**, amm, the, **there is a certain level of anxiety in which you, you, you have the sense that things could erupt, go over the top, explode you know, if you respond in a wrong way will the person, you know, become aggressive or angry or violent or something like that or be just, just be upset or something, and that's been a very common feature I think** in, an anecdote would be, I remember one young man, he'd done very well with us he'd, he'd, he'd been with us for a long time, number of years, he was from a very ordinary background, his father was a postman or something like that I think ammm, uneducated, left school at 15 and a bright and sensitive boy, no his father wasn't a postman, he became a postman, that's right and, aaam, but then suffered a breakdown, was in hospital for many years, then came to us, at first very, very suspicious and wouldn't really engage in any conversation. But gradually over time I developed a relationship with him and he was able to talk and one of the key features of the work with him was that he either began to realise or decided to tell me that he was gay and his father had been very authoritarian and that was something completely forbidden so this became quite a liberation and he gradually started dressing slightly differently and not, he didn't have an earring but that sort of thing, you know, identifying himself with the gay community and feeling confident to do that, happy, happy to do that, to speak about it	*'Schizophrenia' and psychosis are used interchangeably* Fear of something being uncontained *Is struggling for words* Anxiety, need to be careful, risk of an unpredictable reaction from a client Recalls a story of one client Sounds proud of the progress his patient made

Emergent themes	Original transcript	Exploratory comments
Awareness of unpleasant smells and dishevelled appearance Fear in response to client's aggression Fear of unpredictability of client's behaviour	with other people, with the other patients and the staff. Eventually he got interested in philosophy, he moved to less supported flat which we had and I continued to see him, he did a degree at London university and then eventually degree in philosophy and he passed it and eventually, he moved out and lived independently but then after some years he started to become very paranoid again, he came back to see me and we had a number of meetings and I remember the first time he came to see me, and I hadn't seen him for quite a few years, he was dishevelled and dirty and smelling a bit, unshaven and shaking and shouting and it was quite unnerving and I was in an office, not this office but a similar office and I remember the staff said they were all worried because they could hear him shouting in the room with me and at one point I said to him 'you're sounding quite aggressive and I am beginning to feel a bit frightened'. And, you know, it's a very simple way to respond to aggression, and as is not unusual in these cases when you say something like that the person then breaks down which he did, he then started crying and saying 'I am frightened, I am the one who is frightened' and he later he killed himself unfortunately. Amm, and I went to the funeral, you know, met the family and everything, they were very nice and said 'we've done a lot to help him' but so the second point I was trying to make was that amm, **the fear element, the violence, the, the, it's not that violence is always there but you have a sense that you don't know what will trigger** [*R:hmm*] **what will come out somehow**	*Noticing smells and how the client looked. Sounded slightly disgusted* Aggressive shouting Demonstrates how he deals with situations that evoke fear in him Fear Not knowing what might trigger the violence in a client
	R: Are you talking about fear of physical attack or any other	

Emergent themes	Original transcript	Exploratory comments
Fear of verbal aggression and physical violence The role of neuroleptics in suppressing aggression Making sense of client's aggression in terms of psychoanalytic theory Influence of theoretical orientation Being revolted Repulsiveness about clients' physicality	It could be, or it could be just be fear of the chap, the person getting angry or amm, being aggressive verbally or something like that it could be any of those things but often it's just fear of physical violence. Usually if the person stops taking their antipsychotic medication you start seeing these things it's, it's as if something before was contained and suppressed which is now bubbling out to the suffice and it's a bit like the person can't control it so you don't know what will trigger it make it come out and of course this is to do with limits, boundaries the Oedipus if you like something, the lack of containment or the lack of the Oedipal, the cut, the stop, the 'no' or something like that in the being of the person are absent so those are the two immediate two things that came to mind being lost and being frightened. Being, I experienced quite a lot, being, what's the right word, that, was revolted. The person is often quite dirty and, you know, the negative symptoms of psychosis would include probably often not washing and not being hygienic and so one sort of, whether right or wrong I don't know, one's trying to be polite often and shaking hands with the person but then thinking 'wuuu' if they prepared some food for you or something like that, oh God, I'm a bit fastidious probably, so these kind of things and the person is smelly or something like that so some sort of repulsiveness about their physicality that I, that I, I'd noticed that other people don't experience that or don't experience it so much, some do but I notice many don't and that I think that probably obsessive compulsive aspect of me, this is a slight disadvantage to, other people might be a bit more spontaneous and not care too much about, but there is also quite a lot	Fear of anger and verbal aggression Stopping the medication is linked to increased aggression Participant makes sense of client's lack of control over their aggressive impulses in terms of psychoanalytic theory which helps him deal with the difficult situation. The importance of theory and making sense. *Sounds very sure that this explanation is accurate: 'of course this is to do with limits'* Feeling revolted due to clients' lack of hygiene Shaking hands - physical contact is revolting Sharing food (CHT community where meals are sometimes shared with the therapist) Perhaps, this aspect is more important to the participant because he describes

Emergent themes	Original transcript	Exploratory comments
Experiencing pressure to know it all (client's expectation that the therapist has an answer) Feeling lost and not knowing how to respond Pressure to know and produce an explanation Giving oneself permission not to know Not knowing how to respond Automatic or set ways of responding as unhelpful	of talk about, talk about lack of hygiene in people and so on, it's not just me, it's fairly common I would say that people find it a bit repulsive. What else ... ? Often the person is seeking some sort of answer or thinks you know the answer, they have delusions about you knowing all about them, you're assessing them, you're making judgments about them, you know what it all means. Ammm, and **often one is completely lost and not, haven't got a clue what on earth they are talking about or how on earth to respond or what sense to make of it, trying to make some sense of it, perhaps wrongly.** Amm, that, that **whereas that element in the relationship with the person is thinking you know it, you know all about them and you are making sense of it, whether that element, that element can be a kind of pressure which you have to be aware of that, that you feel under pressure to, to know what it's all about, to know what they are talking about and then am, amm, remind yourself that it's ok not to know, in fact better not to know**. But sometimes one can get trapped in sort of trying to be clever somehow or something like that, **not knowing how to respond of course is a big**, **big thing, people come to you and say funny things it's a strange things or nonsensical things and often, one is sort of confronted with not having a clue how to respond and having a number of sort of set ways of responding that sort of slightly gets you out of the situation, gets them off you back somehow, amm, but usually they are not very helpful ways to respond because they are kind of like automatic responses** and the other day, amm, amm, a patient came into the room where my colleague, the clinical	himself as 'obsessive compulsive' and 'fastidious' Believes that feeling repulsed by the lack of hygiene is common experience. Uses the word 'delusion'. I wonder whether it is a delusion though as in fact the therapist is assessing them, judging and has a set of theoretical explanations about clients' behaviour, which the clients do not have knowledge of. Perhaps, he is talking more about being assigned a role one doesn't know how to play. Worries not to live up to clients' expectations? 'better not to know' - is it a way of staying sane? Set ways of responding as unhelpful Brings an example of a good response to a client

Emergent themes	Original transcript	Exploratory comments
The difficulty of hearing what is being said	director of the charity was there, and he came in and said to him "you're, you're the big boss, you're the boss, this is exciting me, I want to suck you dick" and a colleague, I wasn't there, there was other colleague there and she was telling me, she said, it was so good the way he responded and he, he just took it very seriously, you know, didn't lough or didn't rebuff him, just said "you can't suck my dick by you can use me for psychotherapy". And then the chap broke down in tears and said "that's what I need, that's what I need". So that was an example I thought, gosh, if I've been there I bet I wouldn't have responded that well, and more, a less experienced therapist would've, I can imagine plenty in our organisation would've amm, probably been offended and said, they'd respond in Lacanian terms on the imaginary level, they would say something like 'you're not allowed to, you can't speak to me like that, or you're not allowed to use that sort of language or I find this offensive of something like that'. And, you know, that's kind of missing the point but amm, this, this guy [*name of the colleague*], he responded like that, he was getting right to the point somehow that sucking the dick was using, is a way of, talking about using somebody for your sexual gratification or something like that and so he was picking up on that saying you can't do that, you can't use me for sexual gratification, you can use me for this other thing, I am here to be used, you are getting something right, you are wanting some kind of relationship with me so are getting something right, but not just taking it at face value that it's about dick sucking but it's about some other kind of using, engagement, some other kind of intercourse which amm, so I thought that was quite a	Inexperienced therapists are more likely to respond to a client on the imaginary level. Although this is true for any client group, the more experienced the therapist in a particular field the better his or her interventions are. The importance of understanding what the client is saying and not being distracted by one's reactions and surface communication. (Similar to the point made by Participant 2 on importance of managing one's countertransference towards the end

Emergent themes	Original transcript	Exploratory comments
Being thrown by the unexpected response of a client The challenge to respond in the moment without being caught up in the concrete or respond to the superficial meaning Joking as a way of pushing away what the client is bringing and dealing with one's anxiety	clever and brilliant really because it's, it's always, I think the expression is you're on your back, on you back foot, you know what I mean, there is always, i**t's always unexpected that they are coming to say, they say something unexpected and it throws you** it's never, the thing you would have planned to talk about but that's true not just of people with psychosis, true of any patients but they always come with stuff that you're not expecting and so that the skill is to be able to respond in the moment, somehow to what they are actually saying, and not to give in some pre-formed, pre-learnt drivel and really listen to that sentence so, you know how to respond really to the thing that you're being addressed about which perhaps isn't the, what immediately appears to be the thing and spotting what that is what it might be, the inexperienced person in that situation would often make a joke of it and either be offended or they'd make a joke of it, the person says I want suck your dick and the person says amm, 'ok let's go and do it' or say 'that would be fun'. I don't know, make some stupid remark, some way of kind of batting it off, pushing it away, some silly thing	of the interview) Unpredictability Being thrown by the unexpected Although it is true for any client group sounds like with people with psychosis the discrepancy between what they are actually saying and how they formulate it is likely to be higher thus makes it harder for the therapist to respond. (Similar to the point made by Participant 2 on 'I am black' as a way of talking about depression) Importance of developing a skill to respond in the moment Difficulty to respond to what is being said Important not to push it away by joking about it. Joking seems to be a safer option for the therapist as it takes the therapist off the spot light. Similar to the point made by Participant 3 about 'stupid lesbian'
	R: How would you respond?	

Emergent themes	Original transcript	Exploratory comments
"Falling into traps" – not knowing how to respond Influence of experience and frequency of working with clients with schizophrenia on therapist's ability to respond to client Affection	Well, I would like to have responded in the way this chap, colleague responded, I, **I'm frequently fall into all sorts of traps or making a joke or responding in a wrong way**. What I would say is that the more immersed you are in the work, the more you're seeing people with psychosis on daily basis the sharper you are and I know that when I was working on daily basis with people with psychosis, amm, I was much, much better at it. As you get distance from it and you see them less often, you're more used to neurotic people, patients, amm, you lose the edge, you lose the edge something like that, yeah, I noticed that and somebody said the other day, I was talking about it. I' m thinking what else [*pause*] Sometimes there is some affection. I met a chap on the street a few months ago and again a very dishevelled and filthy sort of tramp like young man, little younger than me probably with an equally dishevelled woman and he said to me, came up to me and said to me, are you [*name of the participant*] and I said yes. He said, I used to see you for therapy in 1991 and he said his name, I immediately remembered as soon as he said his name like, I could recognise him. So we talked for a little while how you're getting on and I felt pleased because he said, I always remember that you said to me, I forget what it is now, but he told me something that I had said which actually was quite innocuous you know, something like that, don't give up, or something. Amm, and he said, I always held on to that it, was so useful and I thought, yes, you never know what you say to people, you know, sometimes it's useful, sometimes it's not, but it's the way they hear it as well, seems to make sense to them. It's a little bit like reading a novel, you read a novel one time	*The participant is being very honest here in acknowledging his difficulties* Falling into a trap which feels to the participant as responding in a wrong way Being immersed in the work with psychotic clients allowed the participant be sharper in his understanding and responses to the clients; 'practice makes perfect' Affection *Uses words: 'sometimes', 'some' - I wonder whether this means that he does not really enjoy working with this client group* Recalls an example when he saw an ex-client on the street and felt affectionate towards him <u>I wonder whether the gratitude and praise that the ex-client offered to the participant elicited or enhanced this feeling of affection in the participant</u>

Emergent themes	Original transcript	Exploratory comments
Pleasure in giving an insight to a client that he/she can hold on to and make use of Affection Aspects of common experiences of therapeutic relationship - (normalising the experience) Intense relationship that stays with you Deep affection for the clients and their struggling Being bored by the clients	and it really speaks to you and illuminates your experience and you think gosh you learnt so many insights from that novel, if you read it 10 years later it doesn't mean anything, why did I think it was important? People hear things differently so that point just happened to come together what I said fitted with what he needed to hear perhaps and so it was something he was able to hang on to, help things and he told me about his life which hadn't gone very well which he was in and out of hospital, in and out of various flats and relationships but now he is feeling a bit better, you know, I gave him a few quid and that was, that was it but he was, it was, **it was sort of affection** there somehow, it's like we'd been for a moment, it didn't seem very long but we'd been for a moment close, we had that relationship, like a lover perhaps, **you come close to somebody for a while but then perhaps if you saw that person again you would retain, you know you would realise that you retained something of them,** perhaps many years somehow and that's true of course not just the people with psychosis but in psychotherapy generally. **Such an intense kind of relationship, amm, that I find that one often feels deep affection for them and they are struggling** and, of course that doesn't mean to say that you want to see them, you know, frequently before seeing a person I am thinking "oh god I can't face it!" Often because it's very boring, that's true of not just people with psychosis but you know, people come along and it's often very boring and you're, you're trying to, probably it's the same now you're thinking, this is a bit like being a patient, am, I think generally one is repetitive, but you, it's like you're having a conversation, it's going on over	Sounds pleased with himself for saying something that was important to the client Affection as a result of an intense brief relationship - true for any client group, not just clients with schizophrenia. In some fundamental aspects of experience of the therapeutic relationship working with clients with schizophrenia is similar to working with any other client group Affection - similar to Participant 4 Intense relationship Boredom

Emergent themes	Original transcript	Exploratory comments
Need to think extra hard Difficulty thinking extra hard and concentrating	months or years and at certain odd points something significant emerges but in between those points, there is often a lot of fumbling around and dead ends following little tributaries that don't lead anywhere amm, that of course spotting what's the thing which is the little bit to follow, it a lot to be, is a lot to do with being on top of it, being alert, to being attentive to putting the effort in, really thinking extra hard. I spoke to a therapist not so long ago and he said amm, we were having lunch and I said do you want some wine, he said no I've got to see a patient later and I can't, it's such an effort to think, you know, really hard and attentively about everything they are saying, I just, I just can't do it if I have a glass of wine during the day and I thought yes, he is right, you have to do this really intense thinking and concentrating but I also thought I don't do that half the time, I'm so lazy and my mind is drifting off probably. Although, having said that it is bit like trying to remember something you've forgotten, if you try hard you never remember it. You only remember it when you stop trying to remember it, then it's like free association, then it just comes into your mind sometime. I just went on holiday to France and, and for the whole couple of weeks [*participant's wife's name*] and I were talking about something and what it was then, trying to remember something, couldn't for the life of us remember what it was, no that's right, we went to stay in Paris and we bought something, then we had the bill and it wasn't clear from the bill what it was, for the life of us thinking, retraced in our mind what did we do that day, where did we go. Where we could possibly spend that? It wasn't until we came back from holiday and I forgotten completely about it. [*Participant's wife's*	<u>This point is equally applicable to other clients but shows how work is not that different</u> <u>I wonder whether this participant enjoys working as a therapist at all.</u> Therapeutic work requires the therapist to be alert and think 'extra hard' - true for any client group though A colleague with a similar experience Intense thinking and concentrating while working with a client Drifts off because therapeutic work feels very demanding Importance of letting one's mind be relaxed and respond spontaneously Illustrates the point by bringing a recent example

Emergent themes	Original transcript	Exploratory comments
Relaxed concentration as a general observation on working as a therapist	*name*] said to me, I remember what it was, I bought that sponge bag. We completely forgotten about it, but we tried, tried, tried to remember and you don't tend to remember but things float back into your memory from your unconscious or something when you are not trying and it's the same as listening to a patient. When you are relaxed it's a special kind of concentration that demands that you are very relaxed. When you try you, you can't get that suddenly, but it's not specific to psychosis. Maybe you can ask me more?	General comment on psychotherapeutic technique
	R: Well, I think that was very helpful [was it?] *yeah, absolutely* [ok] *Did it happen that in the room somebody would actually have an acute psychotic breakdown, maybe acute hallucinations or you needed to take them to hospital or something like that?* [yes] *What was it like for you?*	Moving on to the next question on the agenda
	Mmmm, well then it tends to be, I tend to be just doing very practical things, get the person sorted out, into hospital or whatever, at least if that, you know, if, if, into hospital it probably means they are being violent or something like that either harming themselves or about to harm somebody else. If they were just very deluded I wouldn't necessarily get them into hospital. But usually the person is amm, their delusional system is helping them to survive, so amm, one chap for example I've been seeing for a few months and he'd quite typically kept up a front of rationality so didn't seem to be much wrong with him but then things started to slip out and then he said to	Focusing on the practical things when faced with a client experiencing a psychotic episode in a session Delusional system functions as survival mechanism (same applies for hallucinations though)

Emergent themes	Original transcript	Exploratory comments
Theory as a way of helping the practitioner to escape feelings of being lost and being unsure how to respond Engaging in practicalities as a way of dealing with one's fear	me he's, he's square. And, when I started to ask what that meant, I just got a glimpse into his delusional world everybody was either square or round and that that had various extremely complicated meanings. amm, so in that case, I was confronted by huge amounts of delusions or somebody typically talking about CIA or watching through the TV or something like that and how, do, how did I feel? I think what I said before a bit lost, a bit lost a lot of the time amm, unsure how to respond, trying to draw on some theory that might help me to know how to respond. If the person is being violent to me I'd had to get them to hospital then either feeling frightened or probably at that point if you get them to hospital that kind of thing one gets over the fear by doing stuff, so you, you become potent in some way because you are calling the hospital, you are telling the person to put the knife down you are telling the others to go away or become near, you know, you just sort of get into a familiar mode of handling these situations.	Brings a client example Lost, unsure how to respond Seeking help from the theoretical knowledge Fear Practical activities help to get over the fear
	R: If you were to give advice to a therapist how to work with people with schizophrenia or psychosis what would that be?	Moving on to the next question on the agenda
The need to be authentic	Be yourself, I mean this is how we would sort of approach this in therapeutic community, I'd say be yourself, be natural and authentic is the most important thing, rather than playing therapist and sort of saying things you're supposed to say. Trying to find a common denominator with them, trying to find the thing which will link you, will make the relationship could be through doing something quite	(The participant is a CEO of an organisation providing therapeutic support to severely mentally ill, so here he is probably talking about the philosophy he adopted in his organisation)

Emergent themes	Original transcript	Exploratory comments
Viewing delusions as a sustaining the client – critique of biomedical approach to symptom relief Importance of strengthening the client's ego to help them survive their fragility Strengthening client's ego as an objective of therapy	practical like cooking something, practical thing rather than talking amm, it, amm, I would say **not to think of the symptoms as something that, delusions as something that's bad, needs to be removed, but trying to, but that's something that is sustaining them** and we want to do is to try to make them identification with other things that will sustain them and then those delusions will evaporate because they won't need them anymore but not to really be preoccupied whether they are deluded or not. Try to concentrate on building their ego, strengthening, the opposite of what you'd do with the neurotic person who is very defended, you want to sort of break them down a bit, get to the core or their vulnerability and everything. We are doing the reverse with someone with psychosis would be trying to strengthen them, to build them to help them survive their fragility by being identified with others, transference, with the community, with the other, with jobs with tasks, roles, you know, like we have the role of being a therapist, or professional, something like that, students, PhD students or we would want them somehow to, we would try to give them opportunities to find an identity in something other than being a schizophrenic or being a psychotic patient or mentally ill person which is often their role that they feel they identify themselves. We are trying to give them other opportunities to do that.	Importance of being natural and authentic Finding a common denominator as a way of forming a relationship Symptoms as a sustaining force Helping the client to identify with something more than just their illness The role of theory in helping to establish the relationship with the client Strengthening the client's ego
	R: How do you understand 'madness'?	Moving on to the next question on the agenda

Emergent themes	Original transcript	Exploratory comments
Psychoanalytic theory for understanding schizophrenia Psychoanalytic understanding of schizophrenia	Amm, well, we would, I would take a psychoanalytic view which is really that all disturbance comes from these issues around the Oedipus complex whether that's resolved in normal neurotic person or whether it's not resolved in case of psychosis. So, we would understand that **madness is a structure, it's not just a set of symptoms, psychotic person doesn't really ever become non psychotic but that's the way their psychic world is structured**. And in some way amm, ammm, amm, the, you could say that an image, an image Lacan uses is that perhaps not exactly in these words but, would be that, well Freud says that pleasure comes when amm, the desire is stopped. So sex is the easy example, with sex the person becomes excited, more excited, more excited, then there is orgasm, then desire is stopped, they don't feel desire for little while afterwards and that relief from the desire is the pleasure somehow. Pleasure comes from stopping, from limit. And psychotic person and this is like castration, symbolic castration, the paternal figure is saying no to the relationship with the mother to the pressure to satisfy the mother and in psychosis there isn't a 'no', the paternal signifier hasn't been assumed so in psychosis it's like a continual excitement without any stop, without any limit, without any containing. It's like an image of a mad person bubbling, is coming out, you don't know, it's not sort of limited somehow. Something like that, is a lack of, lack of, lack of the symbolic, Lacan would say, lack of language. Amm, something like that and don't know if that makes sense	Participant relies on the psychoanalytic understanding of schizophrenia, particularly the unresolved Oedipus complex, seems he relies on Freudian school of psychoanalysis *Sounds comfortable with the word 'madness' (as opposed to other participants, he also used this word repeatedly earlier in the interview) – uses schizophrenia and madness almost interchangeably* Madness as a structure rather than a set of symptoms Brings example which supports that idea that pleasure comes from limit Explains further the psychoanalytic theory of psychosis. The participant sounds firmly grounded in his understanding of psychosis relying predominantly on psychoanalytic theory. (No mentioning of medical model)

Emergent themes	Original transcript	Exploratory comments
	R: It does. When you used to work with people with schizophrenia what did you feel are your limitations, as opposed to say neurotic clients and depressed or something? [pause] As in do you believe in cure?	I put two questions in one here; instead I should have kept them separate
	No, I wouldn't say I believe in cure, amm, amm [*pause*] what are my limit ... ??	Does not believe in cure. In fact earlier he said that a psychotic person never becomes non-psychotic, psychosis is a structure
	R: Yeah, what do you see as your limitations in working with psychotic clients, patients?	
Limitations of psychosis: difficulty of forming a relationship Therapist's disappointment with what a relationship with a psychotic client can offer	[*long pause*] I think, amm, I was going to say that the limitation is the **difficulty of forming a real relationship with the person** but this isn't really my limitation, that's to do with the limitation of psychosis. My limitation, my limitation is probably, amm, **is probably more to do with my desire, my, I am limited because I didn't get enough out of it, I don't get enough out of the relationship probably.** Amm, it's a very selfish	Finds difficult to form the relationship with the clients with schizophrenia as a limitation of psychosis Felt unsatisfied in the relationship with clients, something was missing
	R: What did you hope to get out of it?	
Lack of reciprocity in the	**A relationship I suppose that is somehow reciprocal and it's**	Relationship with a psychotic client as

Emergent themes	Original transcript	Exploratory comments
relationship with a psychotic client Dissatisfaction in the relationship Sense of oneself as being an object in the relationship	**probably never really reciprocal, it's not always a 100% true but amm, it's largely true, you can't form a sort of relationship you would form with a neurotic person and so you don't get satisfied from the relationship**, **psychotic person doesn't really, doesn't really care for you, you are not really a person in a sense, you are more of an object. There is something lacking in that ability in a sense**, of course you can say well, with the neurotic patient you shouldn't be the therapist because you want to get something out of it but I suppose you do [*laughs*], or you do get something out of it, sometimes more than others, sometimes. May be some affection or gratitude or.	lacking in many respects Lack of care for the therapist Therapist as an object. However, Freudian psychoanalytic approach is based on the idea that clients form a relationship predominantly with the transference object which is represented by the therapist rather than relating to the real person of the therapist. Yet somehow for this participant his non-existence in the relationship is stronger with psychotic clients. Sense of being annihilated in the relationship, used - perhaps this reflects client's experience.
	R: And what do you feel you can give, what can you offer to someone with psychosis?	Moving on to the next question on the agenda
Offering acceptance and compassion	I can offer, I think I can offer, a ... , a relation..., I can offer not caring, a ... , a dis.., I am not, I don't want, I don't care whether they get better or not, or whether they say sane things or insane things or whether they change, progress, all those kind of things. I didn't care whether they have status or job or all those, they are failures, utter failures, they are main failures and lost in life, that doesn't, I won't	*Can't find words, starts and stops. Real difficulty to express his thought here.* Offering acceptance and compassion

Emergent themes	Original transcript	Exploratory comments
	treat them differently to somebody who was very successful person. I think that's more from my monastic sort of formation somehow, it's, I have, I am selfish and lazy but I am able to be compassionate I think, something like that	
	R: Why were you interested in psychosis, where does this interest come from?	
Understanding madness as a way of breaking limits which the participant can relate based on his own desire to break limits Ordinariness of the structure of schizophrenia	Ammm, I, well one answer, sort of rational answer would be it's, I'm not really interested in psychosis, I just happened to fall into this by chance in some way, you know, it's the way things are gone. But I think this is not a full answer but I am only realising it's not a full answer after many years in discussion with colleagues, I would say I've come to realise that I am not, I am not really on the edge of madness, but the amm, but the, but limits and aaaaaam, and breaking limits, the law, breaking the law, of course the Oedipal law is the fundamental law and everything else is a reflection, I would see it like that. Amm, you know we do it all the time taking drugs, getting drunk, drink driving, fiddling the taxes, having affairs, all those things where you sort of, all those ways in which ordinary people break the rules are in some way, and I have all that, are they, in some way they are near to psychosis in the relationship between the law the amm, amm, the 'no' and the transgression of the 'no'. Now, I read in the paper another day that you know Dasy Bassel, you know this ballet dancer, she retired many years ago, she was a very famous English and she was like the head of, prima ballerina at Covert Garden and she	Understanding madness as a desire to break the limits and the law which this participant can relate to (relates to the idea of J. Janes that madness was stopped by emergence of consciousness when the law was invented) Explains his thought with further examples Feeling that 'madness' is not that different from the ordinary structure of the mind Similar to Participant 3 who was saying that she did not see 'what's wrong with them' - the normality of

Emergent themes	Original transcript	Exploratory comments
Working with clients as a way of increasing self-understanding	said in a paper, when her daughters are going out they dress like utter tarts and she discovered that the best way to stop them, make them dress more respectfully, you know, properly is to say to them 'oh, that skirt is far too long, you need to wear a shorter one, that top is too t, too baggy, you need to wear a tighter one' and then 'why don't you wear this' you know and the much more outrageous one and then the girls would say 'don't mummy, of course I am not going to wear that, I'll look like an utter tart!' So in other words, you know, it's like if you make, if you make pot legal, probably lots of adolescents will stop smoking it. There is something built into us which makes us want to transgress the law and these and sometimes they are more in control, we are more in control of that than others, some people are more repressed, those who are completely rigid and in control. Other people are quite out of control and they sort of lose their jobs, loose their marriage and things like that because they, they are doing it, breaking it too much, but then the majority of people are somewhere in the middle where the, they are breaking the law a bit, transgressing the limits a bit here and there but they manage to keep it within control so that their life doesn't spill out of control. I think I understand that this, I see this a sort of related somehow to psychosis and you know which is a total out of control total [*inaudible*] total lack of limit and lack of the 'no', lack of symbolic castration, so I see this sort of related and so I see myself related to it, so in a way it's, it's always about self-understanding, it's about trying to make sense of one's own experiences in this work I think. You know in this book that I've just put together on psychosis and spirituality it's, it's a	schizophrenia, schizophrenia as a social construct <u>Sees the similarities between himself and the people with schizophrenia in terms of fundamental desire to transgress the law</u> (the participant is also a writer)

Emergent themes	Original transcript	Exploratory comments
	continuing making sense of that first therapy session I had with the chap with religious psychosis, you know, that was 25 years ago, but the same questions go on for a while, I think through life. One gets, one has various things one is working out, different for different people but amm, those things are going on through one's life and one's work	Personal meaning in working with schizophrenia
	R: We went through all of my questions, is there anything else you thought I might ask and I didn't?	
	Well, I thought you'd come with lots of little questions, that would've been easier for me	
	R: You've done brilliantly; you gave a lot of information [Have I? Ah ok] *very useful data*	
Empathy	I was worried it would be very little. Amm, anything else. Amm, **I think the thing which I like about working with psychosis is not really, with people with psychosis is not really that they've got a psychosis, it's that they are suffering that, that, you know, there could be other, it's happened, I happened to work with other people ammm, even when I am seeing neurotic people in psychotherapy, they are suffering and that somehow makes me want to help them, try to help them. I think that's because I was suffering as a child I was suffering, I was not in a deprived family,**	He felt it was important to add what he enjoys in this work Empathy and relating to people's suffering Desire to alleviate the pain

Emergent themes	Original transcript	Exploratory comments
Desire to help others originating in one's childhood experiences of pain	**nothing, rather the opposite, but emotionally somehow I was suffering, struggling, nobody was helping me, and I think it left a big imprint on me, one's early childhood experiences, I think they leave an imprint and I was fortunate later, when I joined monastery very kind older people that helped me and helped me to, you know, do well academically and stuff like that but not just that but to find myself, to find myself, and I suppose I am trying to do that with other people who are suffering**, I think, something like that	Relating own pain to the pain of others (Similar to Participant 4 who talked about sensing the vulnerability of the clients and that he could relate to the feeling of being misunderstood)
	R: Anything else?	
	I don't think so	

PARTICIPANT 2 – DAVID
Interpretative Phenomenological Analysis of the interview transcript

R: Text – stands for researcher's interventions
Bold – Notable quotes used in the results section for illustration of the themes
Exploratory comments: Descriptive comments (normal text), Linguistic comments (*italic*), Conceptual comments (underlined)
Square brackets and italic within the transcript – descriptions of non-verbal communication and background sounds

Emergent themes	Original transcript	Exploratory comments
Participant haunted by the concept of madness	**For whatever reason I was always haunted by the possibility of madness from childhood onwards**, aam, and I remember when we lived in Somerset and there was a mental hospital asylum as they were called then at [*location*] and I had a kind of image of this hospital with bars on the windows and so on. This was before I was, when I was age 8 or 9 something of that sort. Aaam, then when I started studying literature I became aware and was fascinated by the fact that Shakespeare in all of his three major tragedies, his three great tragedies portrays somebody who goes mad and I was very interested in that. And seeds were sown for me [background noise and a pause as the recorder was moved] and there was a kind of, I was much influenced by an older friend a very well read person who read a great deal of Freud and Jung and so on and by the time I was aam, aaaah, 21 I was reading not only philosophy and theology as well as literature but also I was increasingly immersed in depth in Freud and Jung's writings and I was also influenced by R.D. Lang 'the Divided Self', so I was without having had much experience I was aam, drawn to thinking about depth psychology and very much in the realm of thinking about whether psychotic difficulties could be worked with psychotherapeutically. And I went to 3 universities at that time, my set paper at [inaudible] religious studies was on Jung and I began to study	Haunted by madness Interest and curiosity elicited by 'strange' buildings and literature Literature as an attempt to understand and capture the experience of 'madness' The literature he was reading must have resonated with him and elicited interest for a reason. I wonder what that was. Interest in psychology and madness from a very early age. Influence of Freud, Jung and Lang on forming his understanding of psychopathology Recalls his biography and various events that led him to working in
The influence of literature (Shakespeare) on eliciting curiosity about and forming understanding of madness		
The influence of R.D.Lang		
The influence of C. Jung		

Emergent themes	Original transcript	Exploratory comments
	at [*name of university*] but that didn't come to any. But I met a rather eccentric woman who managed the students, the students residency at the University of [*location*] and she had a very wise husband who was a Jungian and I had conversations with them both and she said you probably need to be making some money and I wouldn't recommend everybody and but I do trust you in this connection and. So I got a nursing assistance job at the hospital where he was the consultant and so I began to get to know the average inmate of a psychiatric hospital at this time. This would've been 1970-1971, but I didn't pursue it at that point, I embarked on a new relationship and then eventually after having, I was going through sort of Tolstoy phase and imagined I could continue to think and write whilst doing manual work and eventually I gave that up as a bad idea and I, in 1972 in March I walked up the hill to [name of] hospital near [*location*], and asked for a job and they gave me one and at this time at Stoles Hall hospital it had, it was from [inaudible] a mile long, you could, you could race motorcycles down the main corridors from top to bottom and people occasionally did. There is a story about that which I am not going into. Maybe later, but I, I first of all started as a nursing assistant and then I, a wise old Scottish child nurse suggested to me that I should embark on my training and I did and so I began to go through the system and I worked on both long stay wards where there were many schizophrenic patients and acute wards where there were sometimes young people who came with a diagnosis of schizophrenia and I wanted to work psychotherapeutically, **I was fascinated with the symbolism of schizophrenic discourse**. And I wanted to work psychotherapeutically with somebody and I, there was a young man	mental hospital Experience of working both long-term with chronic conditions and short-term with acute presentations Fascination with the symbolism – influence of C Jung?
Fascination with 'the symbolism of schizophrenic discourse'		

Emergent themes	Original transcript	Exploratory comments
	who was, had a delusional system in which he was, he was Adam and it obviously included something about his sexuality and so on but I was very confident that I could work therapeutically with him but it was absolutely vetoed by the psychiatrist whose name curiously enough was the same as my own. In another respect I got on well enough with but there was no one in that, in that hospital who was seriously committed to supporting psychotherapeutic work with, with psychosis, but I did get to know and become familiar with a lot of the implicit process of people with those diagnoses.	Sounds critical of un-therapeutic environment of the hospital he worked in. Influenced by the writings of Laing participant must have had in mind a therapeutic community approach to treatment
	R: So all that was offered was medication?	I wanted to clarify that point as I was not sure what was offered in mental hospitals in the 70s
Desire to work with the most disturbed clients	All that was offered was medication and custodial care, yes. So aam, I went through the system, I qualified in 1975, became a staff nurse, then a charge nurse, then a charge nurse on the ward I was on, I was, I went cross shifts and I would take the most disturbed clients and try and recreational and kind of low key psychodramatic activities for them which was very hard as well	Wanted to work with the most disturbed clients. I wander what that was about - wanting to go into the deepest of the disturbance (K Maroda's idea of therapist's motivation of working with severely mentally ill. She argued that the more damaged the therapist is the more he is drawn to more damaged clients hoping to be transformed by working/ 'curing' those clients. Could this be partially what motivated the participant?) Creative approach - therapy was not allowed so he did psychodramatic

Emergent themes	Original transcript	Exploratory comments
		activities
	R: Very brave as well [Hm?] *very brave as well*	
Fondness towards the patients Fondness towards an 'incurable' patient Belief in positive value of psychotherapy with psychosis	Well they seemed to quite like it, it got them occupied and it was fairly low key staff I had them do, had to do, had them do a Nativity play at one point which was [*laughs*] fairly crazy and also I, **I was very fond of some of the patients** and one was very fond of me and he was aam, quite incurable but at the same time he was and he could be violent but he aaam, he talked to me and I talked to him and I remember taking to him, we've got the funding for buying a whole set of clothes and suit and so on and took him into town and he came back dressed like a, like a black and white [*inaudible*] something like that and he was, suddenly he looked elegant and smart, was highly delighted, it didn't last very long, but nonetheless it, a glimpse of moving into a different world but it wasn't, there wasn't really enough support and hmmm. I, eventually I applied for charge nurse post on the severely disturbed ward and those of us who were on one shift were strongly committed to working in a therapeutic community kind of way as far as we could and the other shift was very custodial in the way they dealt with things. And eventually it all came to a head and we forced the hand of the management and moved and dissolved psychiatric wards and aam, we were all applying for other jobs so that was the end of me and [name of hospital] but nevertheless aaam, I had a, acquired a whole mass of images and impressions and behavioural observations and so on about	Psychodrama activities 'Fond of some of the patients' suggests he had established an emotional connection with some of the patients Interesting that he brings an example of an incurable patient that he developed fondness towards. This might relate back to his 'being haunted by madness' picking the most "mad" to develop attachment to. Describes an incident where he seemed to feel happy for his patient's joy; taking a patient into town He attempted to create a therapeutic environment in the hospital which was against such ideas; shows his conviction in the belief of positive value in psychotherapy with severely mentally ill
	R: For example? [Sorry?] *For example?*	As his story was becoming a descriptive biography I tried to ask

Emergent themes	Original transcript	Exploratory comments
		him for some examples of actual experiences with clients diagnosed with schizophrenia
	it's difficult to, it's more like a feeling, it's, if a client of mine now flips into psychotic mode I'll just spot it like that and some, certain, amm, people struggling with what we call obsessional compulsive difficulties due, as Freud discovered and as Lacan also discovered flip into psychosis, it may be very brief but it's there as a, in other words they, arguably their obsessional compulsive system is a protection from psychosis so when that happens, when someone goes into a grandiose mode or something like that I just, I just spot it immediately and know how to handle it. Aaam, certain of the patients of the [*name of hospital*] had very highly developed fantasy and delusional worlds. There was a huge man who on one occasion I had to take to some kind of medical check-up in [*location*] and at his peak has been 23 stone and one, at one time in an outbreak of rage he picked up an upright grand piano and through it out of the large window of the ward so he was, you didn't mess with him [*laughs*] and there were others who you didn't mess with as well but of course you know, but at the same time you know it was, it's just skilful	Experience of working with clients is difficult to describe in words, it is more of a feeling. A developing "sixth sense"? (Not specific to clients with schizophrenia though) Impressive story of a client's outburst of anger. Yet, the participant does not mention what effect this had on him. Fear of physical threat?
	R: What was it like for you? Weren't you scared?	I wanted to direct his focus back to his experience. "Weren't you scared" was too directive though as it was an assumption that I made
Aggressive & violent behaviour of clients	I was, I was experienced, I mean, and I was amused as well and he, he sat in his waiting room and there was someone there with a baby and he suddenly spoke in his rather sing song delightful voice and he said	He does not quite answer the question and quickly moves on to another story, 'I was experienced' -

Emergent themes	Original transcript	Exploratory comments
Need to respect client's boundaries, limitations and difficulties	'you wouldn't think now would you that that baby there is actually a Japanese general on the streets of Tokyo would you?' [*laughs*] I sort of smiled at everybody [*laughs*] so we went, just got very used to managing these situations and one finds if, mostly if one was not aggressive who was not, if one worked within the limitations of these patients they would, they would, they were mostly fine but of course they did have psychotic crises which would be quite extreme but most of the time they were fine provided you didn't push them into a space. I made a mistake with one psychotic young man trying to push him to get up in the morning and he suddenly leapt out of his bed and, hit me and I, I learned not to push him [*laughs*] from that experience and those kind of experiences I had, I had a lesson from, not directly about psychosis, but obviously indirectly it had a bearing on aam, how all this went, with the charge nurse I was with, I think this was when I was still a student nurse, yes, and this was one of the disturbed wards and in the, the upper part of the hospital there was a kind of circuit were the wards went round and completed a circle or a square and in that square there was a garden and various vegetables and pigeon loft and various things like that so that we could, we could take our patients there, we could lock the thing, the outer door but there was lots of space that we didn't feel trapped and confined and on this particular occasion [Name[1]], the charge nurse noticed astray carrier pigeon on the roof of the asylum and he knew a lot about pigeons and carrier pigeons so he began to talk it down and it came down and he patiently "chuk-chuk-chuk" kind of very softly spoke to it. It would	does that mean it did not bother him and did not evoke any feeling or response? Is he trying to show me how well he could handle difficult and presumably frightening situations? 'Amused' - seems to me insufficient to understand his experience. *'used to managing these situations' - again, it does not sufficiently describe the experience.* *'most of the time they were fine' – does he mean not aggressive?* Need to respect client's boundaries, limitations and difficulties. *Laughs when recalling a client hitting him and also above when recalling a client throwing a grand piano. Is this laughter a sign of nervousness? Anxiety that he is not naming?* Recalls a story of learning from a colleague to be patient with the clients and allow them to move at

[1] Names mentioned during the interview were not transcribed for anonymity reasons

Emergent themes	Original transcript	Exploratory comments
Need for patience and allowing clients to open up with their own speed	move a little bit, and a little bit more, a bit more and so on and there was a nursing assistant, a Polish nursing assistant and, who had no patience at all, and he made a grab for this bird. And [Name] said 'stand, just go over there and keep out of the way don't interfere with what I am doing' and then he started again and he had to start from way back as the pigeon was scared but again, eventually it came, walked all the way into the cage and the door was shut and we had the carrier pigeon. And, [Name]'s patience, just the sheer tenacious patience in that situation was a revelation to me, and always stuck. And that's, and you know in my supervision I mostly acquire wait and see strategy in the way I work. Occasionally, of course you have to dive in and intervene quite forcefully. Amm, so over all it was a matter of a general kind of feeling and sense. I didn't have any, I read, I read 'The extraordinary elucidation of schizophrenic symptoms' that Jung offers in Psychology of Dementia praecox volume 3 in 'Psychogenesis of mental disease' where he analyses his communication of his old lady and [inaudible] the one who has had a highly florid delusional system and Jung makes most remarkable set of connections still worth, remarkable piece of work, well worth reading. I did not have anything comparable to that, but nevertheless I had an instinct that I had a feel for this area of work. I then worked for 5 years in the children's hospital in [*location*] which is where, the job I got after I left [*name of the hospital*] and aam, that was a remarkable experience and there were children who were either autistic or had quite powerful fantasy life and so on and with some of them we did psychotherapeutic work because it was the, the several of the consultants there were supportive of psychotherapeutic work and some of them, some of them register as	their speed Wait and see strategy both in therapeutic and supervisory work 'general kind of feeling and sense' I wonder whether he could elaborate more on this and try to describe it Influence of Jung's work on participant's understanding of schizophrenia 'Instinct that I had a feel for this area of work' - intuitively knowing what is going on and how to respond. I wonder whether this instinct developed in his childhood - the 'mad environment' was not after all
Influence of C Jung's ideas on understanding the symbolism of schizophrenia		
Therapist having an instinct for working with clients with schizophrenia		

Emergent themes	Original transcript	Exploratory comments
Creative approach to engaging clients such as drama therapy Dreams as psychotic communication	particularly interested and would support this kind of work. Ammm, and it overlapped, I mean I also worked with aaam, women who had, in mother and baby unit, who had been sexually abused and were struggling with the processes activated by that. Am, and myself and an occupational therapist set up a drama therapy group which went on for a year which was again very creative process for children who were quite disturbed. I didn't directly work with someone who was fully diagnosed as psychotic but because of the immense power of the child psyche and the effect that it had on staff. One child was an elective mute and I, electively had stopped talking and there was a two year behavioural program and he was approaching a point where he was ready to speak and one of the nursing assistants had a dream that he spoke and the next day and she was working with him on the ward he spoke. And she nearly fell of her chair so to speak this, this child had been a silent observer for 2 years. Aam, and suddenly he spoke and then, so she rang up the charge nurse on the other shift to say 'James, Martin just spoken' [*these names were changed into pseudonym*]. [*Knock on the door*] Can I just check? [*Participant leaves the room for a few minutes and goes to open the door*]	unfamiliar. Describes other settings he worked in Drama therapy group - need for creativity in engaging the clients Draws on his experience of working with children Nursing assistant's dream about a child is interpreted by the participant as an unconscious communication. Dreams as psychotic communication (similar to Participant 3)
	R: Have you got someone booked?	
Collective unconsciousness, noticing similarities between working with children and working with clients	Yes and I did not put that in the diary. So, anyway, we've solved it. So, aaam, the, the whole collective unconscious of the children and the staff was very powerful and the experience of working there was the most difficult job I ever had but also I learnt the most. Aaaam, deep in my interest in all of this, but this was more at, it was kind of, the, it	Collective unconsciousness of the children and staff. I wonder whether he implies that psychotic processes were the main challenge of that job and understanding and dealing with

Emergent themes	Original transcript	Exploratory comments
diagnosed with schizophrenia	was a sort of therapeutic community without being quite formally a therapeutic community, it had a great deal of that kind of flavour about it. On one occasion I found without realising it that I was an Eriksonian psychotherapist without realising it because, both me and [Name of a colleague], the other charge nurse tended to be the, the last port of call if there was a problem. And aaaah, on this particular occasion a particular lady brought her son in and [name of the hospital] was a national centre for epilepsy in children along with Great Ormond street and there was an E&G department and so on, the whole works on the premises. And this lady got into her head that just one slightly anomalous finding on her scan and she got into her head that her son had, had a tumour which no one is picking up. And, aaam, she'd been all around the system and everyone'd been trying to reassure her and of course the more they tried to reassure her, the worse it got and their social worker there [Name] who was an Eriksonian practitioner, he had his office on the, above the stairwell. There was [*inaudible*] residence and sometimes we would see people in the hallway. So, this woman was eventually brought to me and I listened to her story and I was seeing her in the hallway and so I listened to her story and when she'd finished I just spontaneously said to her 'Mrs, whatever her name was, there is nothing I can possibly say that would reassure you'. She immediately relaxed because she'd suddenly been met in her anxiety. And unbeknown to me [Name of a colleague] had overheard it from the stairwell above and I was at a talk about paradoxical injunctions that he gave a few months later in a seminar that, that several of us took part in and learnt about myself used as an example of this intervention [*laughs*] by him because of	<u>them was what he learnt most.</u> Recalls an incident of how he worked with a particular patient's mother (she did not have schizophrenia) (I wonder if here the participant wants to show that he was a good practitioner, this illustration has a slight narcissistic quality to it and shows need for appreciation)

Emergent themes	Original transcript	Exploratory comments
	that, that, that situation. So, there were, I mean there were other things as well which were very graphic and powerful but I'll not.	
	All this is kind of indirect, so aaaam, I aaam, eventually moved across from psychiatric nursing to become a nurse tutor and I taught a lot about all of this stuff and I began to do psychotherapeutic work with one or two of the students that were in trouble or difficulty and I also at that point began to be involved with what became UKCP and so I found my way back into psychotherapy by the back door kind of thing and then I can't remember how it happened, hhhm, but we were still living at [location], but we were thinking of moving to [location]. Oh, I know how it happened, yes, aam, I, I used to do bank nursing at the [name of the hospital] to supplement income and a woman there, whose son had been admitted for a short time was very interested in psychotherapy and got talking with me and eventually, and her son was, she had 5 daughters and then a son. So he was bottom of the [inaudible] and for various reasons she was very in her head and very cut off although she's done a lot of work on it later. But he was quite definitely, he was diagnosed schizophrenic [*coughs*] and we got talking and she said to me would I work with him and I said 'I'm not qualified, I am a psychiatric nurse, nurse tutor but I am not qualified as a psychotherapist, psychotherapist. I do think I have a certain gift. Aaam, and aam, at the same time, if I worked with him it was on the premise that I would, I was doing my best in the circumstance and with the abilities and gifts that I have if you accept that parameter I am willing to attack this'. And I used to, I lived in [location], I used to commute from [location A] to [location B], I think it was once in a fortnight or I'm not sure once a fortnight or once a week and I, I was	Continues with his story of how he qualified as a psychotherapist. I was aware that he was not answering my question of 'experience' and it was more an autobiographical narrative. Yet, he was determined to finish his story which he prepared for the interview. Believes he has a certain gift

Emergent themes	Original transcript	Exploratory comments
	paid under I joined a nursing agency and it was paid for under, she paid the nursing agency which paid me which gave it a little bit professional aaaam support.	
Difficulty in understanding the metaphorical meaning and being caught in the concrete Impact of work on practitioner's objectivity	But I was flying by the seats of my pants really and but I did do two years' work and when I first started working with him he had a very massive delusional system which was, this is the time of the Iran-Iraq war and he was completely identified with this and would talk about his predicament in terms of this Iran-Iraq war. And this went on for several months, I worked in an upstairs room in his house. Then one day I came in and he'd completely regressed and he was now baby and he was just little and frightened and I learned to, I just gently explored which I defined words for things that were going on and he gradually began to go through the stages of emotional redevelopment and hmmmm, [*pause*] I made mistakes which in retrospect seems strange to me but didn't seem strange at the time ammm, so for example he would say 'I'm black' and I constantly tried to make sense of this in terms of his feeling he had black skin and one day the penny dropped that he was, he was depressed 'I'm black, I am feeling, feeling is black' but it was like, I couldn't get to that for months on end, I having to see it in terms of another metaphor and that is a kind of thing happens when you work at these kind of levels you get, you get caught in the concrete. Searls writes about his in the 'Concrete and metaphorical' paper on recovering schizophrenic patients. Hmmm, so I worked for two years and much progress was made and he began to emerge and began to aaam, assert himself with some force and aaam, at this point aaam one can, one can very easily loose one's objectivity in this kind of work and there was a book on anti-psychiatry where	Gentle exploration and reflecting back as a way of working with profound regression – need for patience Difficulty in understanding the symbolic Example of missing his client Being caught in the concrete

Emergent themes	Original transcript	Exploratory comments
	one particular practitioner found himself doing absolutely extreme things with a particular patient who would, got completely up his	
	R: Why do you think that is?	I wanted to explore how exactly this area of work influences practitioner's objectivity
Fear of losing one's sanity as a result of dealing with primal processes of the client	**I think it's because we are dealing with such primal stuff and our own terror of losing our ego and our sanity is so profound** and I'll illustrate it in a different kind of way. When I was a, psychotherapy trainer both at the [training centre] and in Ireland at [name of the college] and also in [location] I devised a, what I call, an institution exercise which was an attempt to go beyond the; do you know about the blue eye, blue eyes-brown eyes exercise?	'Primal stuff' (Participant from pilot interview used the word 'animalistic' in a similar context) – regression of the client triggers fear in the therapist
	R: No	
	There was lady who when she, when Martin Luther King was killed wanted to, she was a school teacher with a particular class and she wanted to use the opportunity to get the class to think about racism from, from the root as it were	Illustrates his point with an example
	R: Oh yeah, I remember it now	
	So on the first day the blue eyes were superior, stats showed that they were superior and, and people probably reacted accordingly. The second day sciences made great strides, we now know that the brown eyes are superior and so the tables are turned. Each day at the end of the day all the children are tested, then on the third day she puts it all together and she finds that on the third day everyone comes out higher on the test than either the brown eyes had come out when they were on top or the blue eyes had come out when they were on top. However, all this was done by authority and I wanted to build into it an element	The participant run an experiment

Emergent themes	Original transcript	Exploratory comments
	of possibility of some degree of autonomous movement between groups but at the same time to build in this kind of ghastly control situation. So I had three groups, aaah, those, the groups were effectively the management group, there was a carers' group and then there was the vulnerable persons group which is patients. And, they, the management group had to devise roles for the working of the other two groups and to give guidance and there was a sister charge nurse had, who was a sole person who could move between the carer's group and the management group. Some of them were, did it very resourcefully and willed and [inaudible] quite subtle kind of way, others got really desperate because of the conflict between the management and the carers' actuality. Anyway, the striking thing was that everybody, everybody who was in the vulnerable persons group, by the way no one was forced to do this and there was a lot of very careful preparation and so on and I never run it for more than an hour and a half because nobody could stand it any longer than that, it was absolute hell. But, the people who went mad found a great liberation in it as it were. They, the ability to be delinquent not be responsible not to have to retain the integrity of an ego and I think that it's that territory that we are talking about and aaam, so, **the pressure on anyone who hasn't robustly done their work in managing their own reactions aaam, is immense and sometimes extreme mistakes are made in this kind of work it is much more likely. And furthermore in this kind of work projective identifications are extremely powerful**. Now, I worked with someone who wasn't schizophrenic but in effect went through a similar pathway and this was a person I worked with the longest and she'd been multiply	group with patients, management and support workers Outcome of his experimental group: liberation in letting go of the responsibility and the need to retain the integrity of an ego is a burden. Immense pressure on the integrity of the ego and the ease with which a participant can make a mistake if unable to control one's reactions. Projective identifications and their
The importance of managing own reactions as a way of resisting the immense pressure on the integrity of practitioner's ego The power of projective identifications		

Emergent themes	Original transcript	Exploratory comments
	abused and we later discovered satanically abused, aaam, from the age of two and a quarter onwards. And, what happened, I realised again, it took me years to realise this that she had worked through each year of her life was a year of therapy and we didn't get to the events that happened at that age until we got to that age so that the satanic abuse realisation didn't, we thought we were, we thought that we were through the worst abuse and we were about seven years into the work and suddenly she got a flashback saying it, it happened again after I came back from the hospital and that was when the really, the intensest and most heavy duty material came out. And, aam, she went really, it was in effect the re-parenting process and she did a lot of it with art work, and she would show me photographs and work with photographs of her childhood and what associations came up and so on and so on. Although she wasn't psychotic there was strong dissociative element in her, in her make up because of the process and there were probably 13 persona that we encountered over the years at different points	effect on the therapist Brings an example of working with another client who was not diagnosed with schizophrenia. Although this client did not develop psychosis, the participant sees the psychotic organisation and processes in the client thus judges the nature of work to be similar to working with schizophrenia. Symbolic significance of the length of therapy. Is he talking about Dissociative disorder?
	R: You talked about that fear of losing sanity [yes] *tell me more about it*	I tried to direct him towards his actual experience rather than more stories
	[*pause*] it's like aaam, staying sane is a constant burden, consciousness is a burden, it is also fascinating, but if one, if one is tired and distressed and so on and so forth it's fragile and the extreme form of that fragility is to be so alienated from oneself that one's making sense of the world no longer connects with a coherent self-concept that one loses oneself concept in the delusional process. Aaam, now as I am sure you are aware I am very interested in the work of Julian Janes on	Gives a cognitive explanation for his experience – fear of losing sanity, this explanation is taken from J. Janes' work. Consciousness as a burden Consciousness is fragile Delusional process as a substitute for

Emergent themes	Original transcript	Exploratory comments
Influence of J. Janes work on understanding the 'normality' of psychotic experiences	all of this and in effect what Janes says is that until somewhere around a 1,000 before Christ we didn't actually have a self-concept in a modern sense. We were guided by gods in a form of hallucinations and voices and you get the record of that particularly in the Iliad and some of the Old testament prophets and therefore his theory is that during the, particularly in that thousand of years of the development of Greek civilisation we developed conscientiousness as we know it but it's a very, very recent and therefore fragile development and it's easily shut away. With extreme sensory deprivation all of us will hallucinate and many of us will hallucinate in situation of bereavement and so on, but 25% of the population had had hallucinations, it doesn't mean you are schizophrenic at all but and aaaam. Some of the major geniuses in terms of the growth of self-consciousness have been aaaaam, themselves had bicameral or hallucinatory experiences: William Blake classical example, Jung, Nietzsche, Shakespeare, Dostoyevsky and so on	consciousness in times of extreme distress Explained the main ideas of Julian Janes' work. Views hallucinations as normal and common experience
	R: But are you saying that when you are working with a psychotic client your fear of losing your sanity increases?	
Staying balanced and in control as impossible endeavour when working with schizophrenia	Yeah, yes, yes, and **it can creep up on you, you think you are in charge but that's hubris, that's arrogance, you think you know what you are doing but suddenly you find they've got in at the back door and your balance is suddenly been undermined**.	Therapist's balance, ability to be in control of the situation is undermined when working with psychotic clients
	R: Describe that feeling	Trying to bring him back to the experience
Feeling of overwhelming catastrophe	Ammm, **It's a feeling of catastrophe, overwhelming catastrophe, and the, the fear of that degree of loss of control is so profound that we would do almost anything to prevent ourselves from**	Describes the fear of loss of control as 'feeling of overwhelming catastrophe'

Emergent themes	Original transcript	Exploratory comments
The importance of allowing yourself to protect oneself, allowing yourself not to get it right 'You're flying by the seat of your pants': The need to take authority and be humble Psychotic communication: client's influence on therapist's dreams, phantasies and moods	**feeling it.** Now, I, **I've learnt that what we do to protect ourselves is also part of the normal order of things** and therefore I don't persecute myself in this kind of work and that means that I can catch the countertransferences and the projective identifications on the wind much more easily than I would once been able to do. Aaam, a lot of this, a very great deal of this I also developed in supervising other people working with, with psychotic clients and what, what, one of the major things **one finds is that people, people have an overwhelming sense of being superego driven that they have to get it right, there must be a right way to work with such and such a person** and of course what I basically teach in supervision is that **you're flying by the seat of your pants and that's the way it is and you need to take your authority but at the same time be humble before the client and follow your instinct much more than you normally would and this is the way it works but you also need to be very sensitive to your dreams, you need to be very sensitive to your own phantasies, you need to be very sensitive to your own moods, if you have moods of despair or great elation you should consider the possibility that this is in some way connected with your client and so on and so forth, it's powerful stuff**	Psychotic organisation of the client is 'attacking' therapist's integrity of the ego which is experienced as a loss of control. The attack is so powerful that the participant sees self-protection as inevitable. 'one of the major things one finds is that people, people have an overwhelming sense of being superego driven that they have to get it right' Desire to get it right, need for certainty and consistency perhaps is an attempt to hold the chaos and uncertainty. Attention to one's dreams, phantasies and moods
	R: You said this sense of catastrophe that you would avoid if you could at all costs. Why, why did you work in that field?	Trying to explore the rewards one might obtain when exposing oneself to the risk of losing one's sanity
Fascination with madness	Well, **it fascinates one because it's, it's the very stuff of the emergence of consciousness**, it's, and also, aaaah, genius and creative power of poetry is very close to the phantasmagorical shaping of psychosis. And aaam, many poets had been at the edge of madness and	*'fascinates one' – seems like the participant struggles talking about his own experience.* Goes on to talk about poets rather than himself.

Emergent themes	Original transcript	Exploratory comments
Psychosis and genius and creativity as close processes 'The dark territory'	some of them gone over it: Christopher Smart, perhaps most famous one there is, Holderlin, and Holderlin aaam, is analysed at great depth by both Jung and Heidegger, so we are dealing with, we are dealing with something very close to visionary experience and possession experience and so on. And most, **most people want to stay within the cultural norms and not go into this dark territory**, Jung certainly was the one who did go in this dark territory and if you ever get a copy or look at a copy of Red book, this is his, this is his record of his journey in these respects, you get some flavour in it memories, dreams and reflections, but also in Symbols of transformation. Nietzsche's experiences in this territory and Nietzsche eventually goes mad, although there seems likely that that was an organic disorder rather that psychosis but the signs are already there in Zarathustra five years before he actually goes mad. [Inaudible] is very close to this, aam, and Shakespeare, Shakespeare clearly understands it and Dostoyevsky both have, have been in this space	Fascination with the non-conscious state of mind Draws a parallel between psychotic processes and genius and creativity. Is he suggesting that for him working with psychosis had helped him to unleash his creativity (Participant is particularly interested in Shakespeare and poetry) Again talks in generalities and then moves on to Jung ('most people want to stay within the cultural norms and not go into this dark territory'). I wonder whether for the participant it was important to cross the cultural norms and explore the dark territory. I wonder what is in it for him.
	R: What is it actually like being a room with somebody having a psychotic episode, hallucinating or something?	The participant talks a lot about literature and other people's experiences and ideas. It was very hard to bring him to his own personal experience. This question was another attempt to do it
Working with psychosis as	Well, as you become more relaxed about all this you just aaam, you in a way behave like a policeman who is speaking to a little old lady who said she's just seen a spaceship land and a green man got out and spoke to her and so on and the policeman says 'how tall was he,	The response is more about how to deal with client's psychotic episode Treat as a straight episode

Emergent themes	Original transcript	Exploratory comments
'ordinary' work of psychotherapists	madam?' and you know, **just treats it as a straight episode. That I think is the way to deal with it, just as we are doing our ordinary work as psychotherapists**	Work is described as 'ordinary' work of psychotherapists
	R: But you didn't notice any particular reactions?	
	Well, all sorts of reactions, at different times, I think in supervision I am probably when I am working with somebody working with someone psychotic I am more likely to be outrageous and a bit off the wall in suggestions that I might make and invite them to really take hold of the work. If that means being quite radical, it means being quite radical. Aaam, there is also a sense of, I'll tell you another story which happened when I was working with this lady long-term. One of the things we did we tried to get support from the health service which eventually wasn't forthcoming. But in the process in 1997 I went to a conference and there was a talk given by a doctor and his patient. It was Dan Dorman and Catherine Penny and colleague and I realised this was going to fill up very quickly and we got there very early and it was recorded because it was one of those conferences where everything was recorded. So I got the transcript and eventually published the transcript in the International Journal of Psychotherapy and I have a friendship with both Cathy Penny and Dan Dorman which is activated from time to time. Well, aam, Cathy Penny was completely diagnosed as schizophrenic when Dan Dorman took her on and she would crouch in the corner of the room and drew and say very little. For two years he worked like that and he reached the point when he was despairing of this work and thinking after all psychosis is an organic disorder and he's got it all wrong and he better give up and go back to orthodox psychiatry and just use medication. In other words he	I wonder what those reactions are. Goes on to talk about supervision and being radical. Illustrates his point with another example from the literature
'Stop being a hero' - the need to become disillusioned		Illustration of an earlier point of

Emergent themes	Original transcript	Exploratory comments
with one's ability to cure as a paradoxical way forward Despair as natural stage towards a way forward Joy in working with psychosis as a counterpart of the despair	stopped being the hero and at that point she started to work. Really deep work and lead to change. She got to the point where she gave up her voices, up to that point for years and years she had voices all the time. She let them go and she started to socialise and she went out with a man and he date-raped her because she had no social skills and ability to pick up the warning signs and so on. So she rang up Dan Dorman and he said 'you've got all the apparatus, Cathy, to deal with this, you've got your exercises, you can, you can manage this and I'll see you on Monday' and she came to see him. And at that point her voices came back and she started, she managed to get rid of the date rapist because she started prying to the Virgin Mary, you see, and he, it spooked him and he run off [*laughs*] but aaam, and she got it back and from then on never again the recurrence of the voices. And she is now, she a fully qualified professional nurse doing work with this kind of clients and so on and has written books and so on. So, whilst she is, she's a bit all over the place, she is most endearing person but she is a bit chaotic but she is completely free of the symptoms system. As I said, Dan went through a process of having to be reduced to despair before it started to happen. So there is a lot of paradox in this kind of work. It is also joy in it.	therapist's need to be humble Desperation as a beginning of a way forward. Sounds like the participant identifies with this and not once had experienced such despair. Joy
	R: If you were to give advice to therapists who work with this category of clients what would it be?	
The need for temperament and gift to be able to survive working in this field 'Going through hell'	Don't do it unless you've got the temperament for it. I think it's a small minority of therapists who've got the gift. Those who have the gift have to **go through hell** to reach the point where they realise the gift they have, but going through that, the people, the great psychotherapeutic discoveries mostly come from people who worked	Temperament and gift as prerequisites of working with schizophrenia 'Go through hell' – very powerful metaphor for working with or

Emergent themes	Original transcript	Exploratory comments
The reward of working with this field – illuminating discoveries about human psyche.	with psychosis. With exception of Freud but Freud in a manner did work with psychosis namely his own in the dream book, he recognised that dreaming is a psychosis and that we make sense of it in psychotic terms. So he came at it sideways, but Jung, Klein, Fairban, Lacan, Winnicott, Jim Grotstein nearly all of these people are people who've learnt the deepest from their work with either psychotic clients or with children. Children in that early pre-Oedipal phase are tapping back into it.	becoming a therapist who can work with psychosis. The reward of working with this field – illuminating discoveries about human psyche. A very fruitful area of work that inspired the greatest ideas in psychotherapy Compares working with psychosis to working with children – pre-Oedipal phase is compared with psychotic organisation
	R: What other advice?	
Ability to manage own countertransference as an essential aspect of working with schizophrenia The importance of being theoretically grounded The importance of psychosis specific supervision Ability of forming symbiotic connections as a critical pre-requisite of work in this area	aaam, **you have to go through long process of learning to manage your own countertransference and being tranquil with it and it, you probably need, anyone who works in this area needs to develop their own theoretical base to make sense of what's going on as I obviously have aaam, good supervision. If a supervisor doesn't get it, change supervisors. You need supervisor who gets this. There is no use trying to work in this area with someone trying to fit it into classical contact work** or attachment, pure attachment base work, of course all these things come in. You have to have a profound sense of the symbiotic connections that are very early emotional developmental level, if someone hasn't got that they can't work in this area. They can do good work in other areas but it's important they don't attempt this. Most people don't, most people instinctively know whether they've got this gift or not.	The importance of self-analysis and ability to control and recognise one's reactions Importance of developing own theoretical base Supervision The importance of having a supervisor who is confident in working with psychosis Profound sense of symbiotic connections as essential ability of a therapist. I wonder whether he is talking about H Searls view on symbiotic relationship as a

Emergent themes	Original transcript	Exploratory comments
		fundamental stage of progression in working with psychotic clients
	R: You gave up working in this field, right? [Yes] *Why?*	I tried to explore what put him off
	Just because the clients didn't come my way, I've continue to supervise	
	R: Because you're working in private practice now?	
	Yes, aaam, I've got, I've got people working, I'm working with people who fringe over into this area, obsessional compulsive, for example. Ammm, it seems to me that there is a continuum and there are as it were lattices where something shifts and the conceptual arrangement changes, Piaget's work is useful in this connection. But ultimately we're all on the same continuum whether we are psychotic or neurotic or genius or an ordinary person. And I believe that most political activities are psychotic and there is a psychosis of normality as well as the psychosis or liberation. So there's another big area.	Touches on conceptual ideas. Psychosis as everyday experience
	R: We're going to finish in a second, just one more last question, what do you see as your limitations in working with schizophrenia?	Moving on to the final question on the agenda
Using intuition in working with schizophrenia	Ammm [*pause*] I don't think I have the kind of massive knowledge of the fine grain of psychotic patterns that someone like Searls has. I think that some of more gifted medical psychotherapists because of their psychiatric background have a sharpness of, a precision of knowledge of what's going on which I wouldn't claim to have. I would work intuitively, I don't know whether that's so, I would like to work with someone again because I would like to attempt to apply what I've come to know by long reflection and processing about all of this over the years and find out what I can do.	Working intuitively versus having precise knowledge of what is going on in psychotic mind Interest in working with schizophrenia

Emergent themes	Original transcript	Exploratory comments
	R: It sounds like you can do a lot	
	I suspect so, I suspect	
	R: Thank you very much, anything else you would like to add?	
	Ammm. I don't think so really, I don't think so. Ammm, well worth just in this connection getting the book that Dan Dorman eventually wrote which is called 'Dante's cure'	
	R: yeah, you mentioned that before	
	Well worth it, alright.	

PARTICIPANT 3 - EVELYN
Interpretative Phenomenological Analysis of the interview transcript

R: Text – stands for researcher's interventions
Bold – Notable quotes, used in the results section for illustration of the themes
Exploratory comments: Descriptive comments (normal text), Linguistic comments (*italic*), Conceptual comments (underlined)
Square brackets and italic within the transcript – descriptions of non-verbal communication and background sounds

Emergent themes	Original transcript	Exploratory comments
	R: so, tell me about your experience of working with clients diagnosed with schizophrenia.	Opening question
Enjoying work Working with clients diagnosed with schizophrenia is the most stimulating work	Oh, Gosh, that is a very broad question. I'll just have to free associate. Aaam, well, **they are my favourite clients to work with**, aam, yeah, they are my favourite clients to work with, **I find it the most stimulating work that, of all the work I do**, ahh	There is a lot to be said about the topic Participant finds these clients fascinating. Does this work feed some internal need in her? "Stimulating": engages the participant mentally and/or emotionally. Reward. Need to work harder, to understand the client's desire to discover something not easily accessible? Evokes curiosity?
	R: In what way?	Prompting for more details
Intellectually and psychologically stimulating work	Because so much, i**t's such a lively work**, ahh, it's **lively sort of intellectually but it's also lively in kind of emotional and psychological sense**; it's never confined to just the hour that you're	Work is lively, engaging, Gives the participant the feeling of being alive, full of life? Never stopping work?

Emergent themes	Original transcript	Exploratory comments
'Taking clients home'	working, it's always going on in a very sort of lively way in between sessions. That's what my experience is.	Holistic involvement of the senses (intellectual, psychological and emotional) Sense of mystery Work doesn't end after the client's gone. Can be seen as intrusion onto personal life perhaps which might suggest client's narcissistic demand/need to be constantly cared for in emotional sense or perhaps is a manifestation of a very strong symbiotic relationship (H Searls)
Psychotic processes - dreams	Ahh, so if gave you some examples of that would be, ahh, that for example **it's pretty much only working with psychotic clients that I have this experience where I dream about them very, very vividly**, aam, sometimes dreaming, occasionally dreaming actually about them, but more often I am not dreaming about them it's only when I wake up that I realise that it's to do with this particular client	Vivid dreaming about clients. Powerful way of communicating the material that cannot be talked about
	and I suppose actually without wanting to freak out any future potential therapist, actually I think what's happening is that I am having psychotic processes and aam, you know, sometimes that can be very alarming but at the same time it's so, you know, stimulating it's just a kind of work when you think about aam, aaah, shall I, can I give you some examples	"Psychotic processes" - explains her reactions in terms of unconscious communication. Countertransference In order to receive such powerful communication I wonder whether the therapist would need the ability to regress to paranoid-schizoid position yet have sufficient ego strength to restore the sense of reality.

Emergent themes	Original transcript	Exploratory comments
		An ability similar to empathy, being perceptive to another persons' feelings, yet, not all therapists report this, talent or familiar experience?
	R: Yeah, sure	
	Ok, aam, when I think about a client that was my first client today aam, whom I saw at 10 o'clock, and she has a diagnosis of schizophrenia, and she's also got a diagnosis that she rejects of Asperger's but I think whoever diagnosed her picked up something there because she has such an unusual kind of way of communication, she is very sort of straightforward and you know that kind of thing. Aam, but actually I met her about two years ago and somebody that I worked with given her my number and we had about three attempts to get the therapy going. So, she kind of turned up for initial session and in her sort of inimitable fashion just kind of sat there and said something along the lines 'I want to tell you about when I had my breakdown' and so she just sort of told me about her breakdown which was a lot about, you know, really sort of disturbing psychotic experiences that she had, she was very delusional and she had a lot of experiences, she still has actually, we're talking about this morning where she thinks, funny enough that everything is being recorded [*laughs*] but that there are sort of two-way microphones going on and all of these kind of things. And that was it, it was all very full on, aam, and off she went and the next day she texted me and said that she didn't want to come back any more. Thank you very much, you've been very helpful [*claps her hands*] and she didn't want to come	Describes a client to illustrate a point of unconscious communication Three attempts, difficulties in engagement and commitment which requires patience from the therapist Makes connection between client material and current situation - me recording our conversation Session was full on, intense, <u>demand on the therapist to process high volume of disturbing material</u>

Emergent themes	Original transcript	Exploratory comments
	anymore and I was like ok, fair enough, aam,	
	and that night, was it that night? It was either that night or the next night but shortly afterwards I had the, which I have to say was really horrific dream and I dreamt that, that I'd killed somebody. I didn't know who I'd killed how I'd killed them or why'd killed them but I'd killed somebody and I was trying to get away from the scene of the crime without drawing attention to myself, that's what was going on in this dream and I, it's so vivid as I am speaking about it now I can pic..., literally picture it, the scene, it was very sort of urban sort of run down urban area and I was sort of walking really fast and really trying to kind of you know do that thing of act normal, kind of thing, you know, don't let anyone, whatever, and then to dream, in the dream it was like it had gone back to the beginning again and that I was back at the beginning of the road that I've been walking down but this time I'd killed somebody else so I now killed two people and again I didn't know who I'd killed or why I'd killed them and I have to say in this dream you know sort of emotionally I wasn't even thinking 'oh no! oh no! I'd killed!!' I wasn't even thinking about that, I was just experiencing this intense sort of terror that I'd killed somebody and someone is going to find out and again it was my focus in this dream it was to get out that place without anybody noticing but this time, aam, you know I felt like I was really giving myself away because I was sort of shaking and all of those type of things and when I woke up from this dream, aah, you know, sweating, was really, really horrible horrible dream and I sighed thinking 'oh my God, what kind of, what on earth is in my head that I can possibly dream something like that, aam, but then as I sort of woken as you can	Recalls a vivid dream in detail, difficult and powerful emotions were experienced in the dream, those emotions perhaps resemble the feelings of the client Client's attempt to communicate to her therapist her 'intense terror' of the loss of her twins, perhaps this experience was preverbal thus couldn't have been communicated in any other way. Following M Klein's view such experience occurred during a paranoid-schizoid position and could've contributed to a fixation at that stage? Intrusive presence of client material throughout the day

Emergent themes	Original transcript	Exploratory comments
	imagine I spent quite a lot of time during the day thinking about this dream and it you know I was just processing	
Powerful unconscious communication with psychotic clients	I kind of thought to myself this is got to be something to do with one of my clients but I couldn't quite sort of piece it together, I couldn't quite get it together and then about a couple of weeks later this client that I'd seen the day before or a few days before phoned me up again, she said 'oh, I'd, actually I'd decided I would like to come back to therapy after all, is that ok?' and I said 'yes'. So she came back and in her again inimitable manner she sat down, actually it wasn't in this place it was in another place where I used to work about two years ago, and she said, I want to tell you my story and I'm like 'ok, you know, let's, let's talk about your story, I'm listening' and she mentioned a whole lot of things about her childhood and one of the things that she mentioned was that she was one of triplets and that two of the triplets had died and she was the only one that had survived and I was thinking as she was telling me I was thinking 'God, blind me, what an unusual thing, I've never met anybody bla-bla-bla-bla-bla'. And it was only later, actually, funny enough it was only when I was recounting this to [name of her supervisor] in supervision sometime later and he said 'well, that's obvious what that was about' and I was, I sort of said what do you mean? And he said, well, you know, didn't you dream that, so I had, I had, this is the way I make sense of it, **there is something about working with psychotic clients where they communicate on a completely different level**	Participant links that powerful dream to her client work Client material that relates (and could explain?) the content of the dream Supervisor's attention to unconscious communication, makes sense of her dream in terms of psychotic communication Unconscious/symbolic communication is a particular feature of working with psychotic clients
	R: Very powerful level	

Emergent themes	Original transcript	Exploratory comments
Intense powerful experience Empathic response towards client's traumatic experiences Non-verbal ways of communicating with psychotic clients Role of theory in making sense of unconscious communications - theory	Really, **really powerful level** and actually, we, there was then a break of about another year, and then about three months ago she's come back and now we are working again and of course it turns out that this poor woman has had the most horrifically traumatic life which of course in the medical system people don't even ask people with schizophrenia about, you know, traumatic experiences and so on and so forth, and so, the way I make sense of it is that it is a good example of the way that **a lot of psychotic people somehow, you know, communicate or how we communicate together is that something is said in words, some things, you know, happen in the room, and some things happen via, via dreams** and I think, you know, I'd go along with that sort of idea which probably is Kleinian or something, I suppose, you know that we all have the different layers and one of the layers is psychotic layer and that you can share a communication on that level	*'powerful' – participant also frequently uses words such as 'intense', 'stimulating'.* Client's story *Empathy and compassion in participant voice towards her client Sounds critical/disappointed with the medical system.* Experience (unique?) to psychotic clients comparable to a strong countertransference reaction. This type of communication engages both thinking and emotions and perception - thus feels powerful. Is it intrusive though? Theoretical explanations of the experience. M Klein and relevance of her concepts such as regression to paranoid-schizoid position. How can the therapist facilitate such 'psychotic communication'? What is the role of therapist's life experiences here?
	R: What is it like to be on the receiving end of that communication, very powerful?	Prompting the participant to talk about her experience in more detail
Experience that comes with time; terrifying at the begging	Well, hmm, I would say it takes a bit of getting used to because I can remember the very first client that I had who was very floridly psychotic and even though at the time I worked in mental health, I worked at mental health crisis services, so I saw a lot of people that	This shows that working with psychotic clients is different from working with the 'worried well' and being on the receiving end of such

Emergent themes	Original transcript	Exploratory comments
Fear of physical attack with the very first client	were floridly psychotic but **he was the first person I'd seen as a psychotherapist and I was completely terrified**, really, really terrified, I felt aam, I felt, I mean there was a lot to it because the assessment that had been made of him did not pick up that he was psychotic, it was only later that I found out that he had a history of psychosis but nobody had picked it up, he was a, he was an Iraqi refugee and, you know, there was one thing and another nobody had picked up this sort of history in his life and somehow actually they hadn't even picked up the fact that he had been in touch with services and it was recorded that he had psychotic experiences but anyway for my purposes **it was a real shock so that I didn't know that, you know I wasn't expecting that and it's interesting actually how I'd experienced it because how I experienced it was personally, I thought he was, I was reacting as if I thought he was going to attack me although actually he'd not said anything or done anything to indicate that that was a possibility**	unconscious communication is difficult / shocking, at least at the beginning. Fear, terror Recalls the details of the history of a particular client to illustrate the point The participant was unprepared as nobody had warned her the client was psychotic. Stressful and frightening as he was her first client "Shock" and fear of physical attack Participant was feeling threatened
	R: So the fear of physical attack?	Clarifying whether it there was more than the fear of physical attack
Fear of physical attack was more characteristic of early career	Yeah, yeah, I, yeah, I think that's how I was making sense of it I thought he was going, that there was risk that he was going to physically attack me. I felt physically threatened. Amm, but I would say subsequently I, you know, when I've been seeing psychotic clients maybe for a bit, you know, say couple of more years, aam, **I never again had that experience of feeling I was going to be physically attacked but I have had the experience which is very rare, haven't happened in the last at least 7-8 years let's say, but**	Physical threat Physical threat was a one off experience? Is it related to lack of experience or just a coincidence?

Emergent themes	Original transcript	Exploratory comments
Psychological threat	**for a while I used to feel kind of attacked in my mind** ahh, because	Psychological attack
	R: Describe it	Prompt to elaborate this point which seemed of interest
Confusion	Well, feeling, **feeling so confused**	Describes the experience of being 'attacked'
	R: Like invasion in your mind?	This clarification is too leading
Control over psychotic processes	Ammm, I don't know if I could say that, that I would use the word 'invasion' although when I think about, I suppose it is something like that but the raw experience of it is just being, it's obviously **I've chosen to tune in to what the person is experiencing and their mental state**, I've chosen to tune into that **but in doing that** I've got the amm, **I've got the sort of the energy of it in my mind** and I …, you know, it … , that can be … ,	*Struggling to accurately describe this powerful and complex experience of mental attack* Conscious decision to 'tune in' to 'be attacked' - conscious control Empathy. <u>The observing ego is in control?</u> Experiencing the emotions/energy of the client *Is there an underlying difficulty in articulating something this emotive (starting and stopping a sentence, struggling to find words)*
Impact on the cognitive processes of the therapist: altered state of perception, memory, understanding and reasoning	it can make **you feel like you lost grip of your sort of rational processes, it's like you can't think properly or you can't, you can't remember, if you try to remember what the person has just said you can't remember what they've just said, you can't remember whether there is a thread to what they've been saying,**	<u>Attempt of the client to 'drive the therapist mad'?</u> (H Searls) Interference with conscious processes of the therapist such as memory, reasoning, logic etc. Can be explained

Emergent themes	Original transcript	Exploratory comments
An alarming experience of 'losing one's mind' characteristic of first years of working with psychotic clients Mastery over being in 'psychological danger' which comes with experience	**you can't remember what you said you can't think what to say next so it's a really** aam, **confused and that, that can be an alarming experience**, if, when I have that experience now, which I do sometimes with particular clients, I'm not alarmed by it but **years ago I used to feel really kind of quite threatened by that and sort of have this sense of being in a bit sort of psychological danger like I might sort of lose, lose a grip** now I don't, I don't feel like that,	in terms of countertransference, an attempt of the client to communicate his own confusion, loss in the time and space, his way of experiencing the world (Paper on memory 'hope and expectation' - memory loss communicated via countertransference) Confusion was an alarming experience for participant in the past Fear of losing one's mind Fear is no longer there, the experience was so common that became the norm, thus no longer alarming or worrying. The participant seems very welcoming of such experience and finds them a useful tool to facilitate communication and empathy

Emergent themes	Original transcript	Exploratory comments
Enjoyment and fascination with the work Impact on the therapist: total confusion and inability to stay with rational thought process	I mean I had this client who actually I just saw for assessment and didn't see him anymore which was sort of to do with the funding issue but he was deeply, deeply thought disordered, aam, and he kind of sat there where you're sitting now and I really liked him, I really enjoyed the experience, he was so, there was so much going on and I found it really sort of fascinating kind of just tuning in and kind of going along with it, going with it, amm, but there was absolutely no question **I was completely and utterly confused I couldn't bring to bear any kind of amm, or very little rational sort of thought process into what was going on**.	Recalls a session with a particular thought disordered client to illustrate the point (Participant worked with both positive and negative symptoms of schizophrenia) Enjoyment and fascination with the work Confusion, difficulty to follow the client
Altered state of consciousness, un-articulable experience of confusion Split experience: rational and conscious, and emotional and experiential	Amm, and I remember [*laughs*] when he left I went out into that garden [*points to the garden outside*] and I was just, a part of me was observing what was going on the whole time but I went out into that garden and I just stood there for five minutes kind of like that [*makes a face*] and then I just sort of said actually out loud to myself 'what the fucking hell was that?!' because it was so, **it was so sort of un-articulable at that point** but actually later on, in fact later on in the day, I can't remember, I took my notebook and I decided to write down what I could remember of the, of the, you know, and in fact of course there were many very concrete things that were being communicated, lots of really, it was a really good assessment, I mean in terms of what you want to find out in an assessment, it was rich, it was packed but	The experience is powerful and irrational. <u>There seems to be a split where a part has firm contact with 'reality' - the observing part and another part is more able to regress with the client to be able to understand the experience</u> Un-articulable. <u>Preverbal experience of confusion?</u> <u>The impaired reasoning of the therapist is a temporary experience while with the client - powerful effect of the client on the therapist</u> Two level experience

Emergent themes	Original transcript	Exploratory comments
	R: On a different level it was confusion	
Confusion Flexibility and creativity to adopt to the needs of a floridly psychotic client Allowing yourself to following your instinct in the work	Totally**, in an experiential bit it was utter, utter confusion**, **I had no clue what was going on**. Amm, but you, you know, from my point of view it, it wouldn't have been, may be it would be if somebody else was to do it, but I couldn't do it, it wouldn't have been possible for me to try and conduct an assessment or a session with somebody who is floridly psychotic by trying to take them through some kind of sort of rational checklist of some kind of chronological, you know, history taking, it just didn't, that's not how, I don't know, that's not how it works, is the way I kind of see it. I suppose it depends what it is, what it is you're trying to do or what kind of work you would be trying to do, I suppose if I was a psychiatrist or I was doing risk assessment or something like that may be I would try and approach it in a different way but that's not the way I work and I suppose that is because I am integrative psychotherapist and the basis of the way I work is, it's humanistic so I have, I suppose what I am, you, that's very hard to articulate but I suppose what I am doing is that I am using, utilising the real relationship and in order to do that congruently, authentically then I have to get where they are in some way. So, that's not, that's not just, that's sort partly, if you like a sort of technique just that, I've, just the way I've been trained, I'm integrative so I've been allowed to sort of follow my own kind of way of doing things, so that's like a way of working but it's also with an eye to what I think is going to be the way to help this person	Experiential level - confusion Placing a lot of importance on connecting with the client emotionally, sounds disapproving of practitioners who remain purely rational during assessment without attempting to enter the experiential world of the client (*sounds dismissing when saying: "may be it would be if somebody else was to do it"*) Need for the therapist to adjust the way of working to adopt to the needs of the client, need to be creative Reflects on the type of assessment which she finds useful in her practice. Check list assessment is seen to be more appropriate for trying to establish a diagnosis or for risk assessment, but not for therapeutic purposes Defines her therapeutic approach: integrative with a strong humanistic foundation

Emergent themes	Original transcript	Exploratory comments
		Finds it difficult to describe her own integrative blend. Theoretical rationale 'to get to where they are' does she refer to being responsive to unconscious communication above? Defines her freedom in using techniques/approach. Focus of client's needs
	R: Would you term it countertransference?	Referring to the description of 'mental attack' earlier on
	Yes, I would, I would call it that, yeah, I'm happy with that term	Need to work with countertransference?
	R: Has it ever happened that a client would have a psychotic episode in a session with you. [P: nodding] *What was it like for you?*	Prompting the participant to talk about her reactions/experience/responses to the client in the moment
	Well, when I, when you say, when I say 'yes' to the question 'has somebody has a psychotic episode' in the session, when I was saying yes to that what I mean is that clients would often be psychotic, is that what you mean by that or did you mean just?	Clarifies the question
	R: I suppose having hallucinations. [P: yeah, yaeh, that happens a lot] *What is it like?*	Clarification
There is no one standard	Aaam, well, depends, really, depends I suppose what kind of, what, I	She is not thinking in terms of trends

Emergent themes	Original transcript	Exploratory comments
experience typical of working with psychotic clients Working with client's hallucinations does not affect participants thinking and is experienced as a 'normal' session Normalisation of working with clients diagnosed with schizophrenia	can free associate, I can just pick any examples, can't I? But let's say for example it might be somebody who is a voice hearer. And with some clients I will do some aam, I suppose voice dialogue work, aam, that's really interesting question because then yeah, somehow with things like hallucinations it doesn't affect my thinking so much, not quite sure why is that such a, I am really glad you asked that question I need to think about why that is later on but, aam, so in cases, in examples like that, in a sense it's quite sort of aam, **it's just like a normal session in a way and it's just that the topic of conversation is about the experience of the hallucination** and say, for example, aaam, I mean obviously it depends on a client because some clients have more of a distance on what's happening than others.	does not want to generalise. Sounds like she is comparing various experiences. Non-generalisability of experience of working with schizophrenia Brings up an example Compares her reactions to client's experiencing different symptoms. Thought disordered clients cause confusion, clients who didn't give sufficient information about traumatic events come up in therapist's dreams? Hallucinations do not evoke sense of confusion in the participant. Participant is surprised that it didn't occur to her before to notice different reactions Highlights normality of the experience (similar to P2 and P5) Therapeutic work isn't essentially different. Both client and therapist manage to split off the psychotic layer? Therapist response might depend on the degree of client's awareness
	So I might have one client for example this young lad that I used to see was, heard a lot of voices aaam, and he knew that and called them voices but he was very in the experience, he found it difficult to know	Brings a clinical example to clarify the point Description of a client's hallucinations

Emergent themes	Original transcript	Exploratory comments
Use of humour in dealing with anxiety provoking situation	whether or to decide whether it was real or not. And, so, I can give you one example, when I was doing the beginning of some voice dialogue work with him and we were talking about the voices and aam, the voices, he would be hearing the voices in the session and so I would be asking him what were, voices were saying and aah, one that really sticks, that sticks in my mind is when he, he was saying that he was, the voices were telling him that I was a stupid lesbian and then he sort of, which, actually I am not a lesbian but I think that wasn't the point, I think the point was that it was supposed to be derogatory and he'd sort of said 'god, you're sure you want me say what they said about you?', yeah, please, you know, bring it on, tell me I am listening! They said that you're, actually they said you are a stupid fucking lesbian, was the actual, you're a stupid fucking lesbian, 'I'm really sorry, it wasn't me, that's what they said', 'umm, ok, you know, that's fine, that's fine, that's fine, but tell them 'i.e. I'm not stupid and I'm not a lesbian either, but still not to worry'.	Therapist is part of client's hallucination, client's experience is warded off and perceived as hallucination – anger towards the therapist expressed as a derogatory attack? Does humour help to diffuse an overheated emotional situation, the demand placed on the practitioner is high (anger the client is not aware of). Humorous reaction gives a practitioner some time to gather her thoughts before taking it seriously and responding. This is not to say that participant took her work lightly, but to acknowledge the highly emotionally charged situation.
	Kind of said, I mean that is a little bit alarming because it kept, you can see that that potentially could be a bit embarrassing because, you know, they can say anything about you and you're asking them to say it, you know, but actually it was ok and I think we just used, I certainly I do about him, but I used humour as a way to get kind of round that.	Client's uncensored thoughts and emotions towards the therapist can be communicated via hallucinations which is potentially uncomfortable, embarrassing or intimidating for the therapist Participant used humour to deal with

Emergent themes	Original transcript	Exploratory comments
		the situation. Confronting the clients wouldn't have been useful at this stage as client's feelings are split off and projected away.
Suggestion of how to work with hallucinations: treating it as a straight episode Respecting the fragility of the client Enjoying the work Affection and fondness towards the client	Amm, and then actually with that, with that, also with that client we did some, I asked him, this was after a few months if amm, I could, if he thought that I could talk to his voices and a, very gamely he said 'yes' that he thought that he didn't know but we could give it a try and so amm, I was, it was a very bizarre situation because he was sort of acting as interpreter between me and his voices of which I think if I remember rightly there were about three of them. And ah, so I'd kind of like looking at him and sort of asking question and say things, you know, I'd say something like 'can you ask them', so we were keeping it a little bit of a distance not, you know, not directed at him as if it were actually part of him, because he didn't accept that it was part of him, 'can you ask them, you know, kind of, you know' and then he'd sort of, it makes me smile because he sort of gamed for it, tried so hard to really go along with this thing which actually he thought was completely barmy, he was humouring me and sort of go 'well, ask again' so I'd say, ok 'can you ask the voices why is it you're keeping having a go at him, why is it, you know, being, you being so nasty to [client's name] earlier on?' and he'd sort of go [*makes a face*]. What I think he was doing he was trying to repeat it in his head directed at them and then he kind of go like this so 'they said it's because bla-bla-bla' amm, so, so that would be an example say of, of working with hallucinations	Demonstrates an example of a 'voice dialogue' work 'Bizarre situation' - typical of this client group? Need to think outside the box, be creative Taking client's experience seriously Respecting the fragility of the client *Participant sounds fond of her client (her tone of voice and facial expressions communicated fondness)*

Emergent themes	Original transcript	Exploratory comments
	R: Sounds like you were very much in control of what was going on	Trying to bring her back to her experience and her own reactions rather than focusing on client's story
Normalisation of working with clients diagnosed with schizophrenia Working with hallucinations is interesting Mentally stimulating work Compassion / deep empathy towards client's suffering or fear	Yes, it certainly, I was in control of my mind in a way that, that I not at other times I've described to you before so to me that is not that different to working with any other client. Aah, it just feels, **feels quite normal, just like a normal kind of session as it were**. **Obviously it is really interesting**, aam, I don't want to say any of my clients are boring but, you know, **it's slightly out of the ordinary, it's stimulating** it's sort of, you know, whatever aam, other, other clients really very distressed are very sort of, you know, s..., very in the experience I'm finding it really hard to kind of come out of it, that, it so depends on who it is and what the, what the situation it is, but obviously if someone is having, you know, lots of kind of delusions and voices and very, very paranoid and frightened and all of those kind of things then you know on an empathic level it, it's heart-breaking it's heart-breaking to kind of you know see what they are going through, aah,	Repeats that the thought processes were not impaired during this work. Nothing unusual, special about working with this client Curiosity about the psychotic material, mentally stimulating Clients' distress has an impact, difficult to 'come out of it' Strong compassion and empathy? Recognises the suffering, the deep emotional understanding of client's experience which is heart-breaking
Rationalisation as an unhelpful technique	and I suppose actually you see again it's not really possible, well certainly the way I see it, it's not possible and it's not advisable I don't think to go straight for the trying to rationalise them out of it am, at some point you, I think I do have to do that, you know when they are really distressed or if they are in danger or anything like that I would definitely have to do that but the run up to that to me it doesn't seem to be any way out of it you just got **to tune in with them**	Comments on technique and what is useful in therapy. Participant highlights that you would need to stay with the client's experience as you would with any other client, confrontation about finding the 'truth' are unfruitful and pointless unless

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Empathy is crucial in this work Importance of establishing an emotional connection, allowing to be affected by client's distress as a way of relating	**empathically same as you would with anybody else to facilitate them being able to communicate to you, you know, genuinely** un.., un..., you know without having to worry you know me interrupting them or me trying to say you know that's not happening or any of that, aam, so yeah, that can be quite heart-breaking and you know in those situations	there is real danger (similar point made in Pilot interview). Humanistic stance Rationalisation is not useful - criticism of cognitive model (CBT)? Importance of establishing trust, by being sensitive to client's experience. Importance of empathy. The actual therapeutic work is no different to the work with other client groups. Challenging delusions is unhelpful
Spectrum of how a therapist experiences this work from being rational and grounded to being utterly confused as mimicking various degrees of 'madness'	as I am talking about this I am kind of thinking **it's almost like as if there is a spectrum of being this type of work**. **Some examples where I, I am 100% or pretty much 100% grounded in reality**, let's say that example I just gave you there I pretty much experienced myself as grounded in reality and then **you've got the sort of real extremes of it where you just feel like you haven't got a clue what's going on and then there are other examples where you sort of you are on a kind of slightly, you definitely not grounded and you haven't completely lost it but you're on a sort of different plain**, yeah	A spectrum of or different types of impact of a psychotic client on the therapist. A measure of regression that a therapist can reach in response to a particular client or particular client's experience? Reduction in cognitive abilities which gives room for expression of unconscious and psychotic experience. Is it the nature of client's material or the level of client's disturbance that would determine the level of regression in the therapist?
	R: What do you feel when it happens?	Referring to the extreme end of that

Emergent themes	Original transcript	Exploratory comments
		spectrum
Therapist experiencing psychotic processes -altered state of consciousness Alterations in therapist's perceptions	Sort of aam, feel a bit, aaam, well kind of psychologically now that I've given you that example I'm thinking of a particular client. Aam, **physically I feel quite sort of literally off the ground and psychologically I feel off the ground, so I feel like I am sort of floating** a bit, aaam, and sent you, **I have quite a lot of sensory sort of experiences which I suppose is getting into this, sort of this psychotic layers being stimulated a little bi**t but like colours would be very bright, aaam, that's **the thing I am most aware of as I think about it, it's colours being very bright, as well having sort of slightly distorted perceptions**, I, not kind of seeing absolutely seeing things that aren't there but things that are there in the room seeing, you know, brightly coloured, moving a little bit, things like that.	*Difficulty to find words to describe this feeling* Powerful experience affecting both physical and psychological state and perception. Freudian split: the observing ego of the therapist stays in touch with the reality, whereas his experiencing ego is regressing to paranoid-schizoid position. This allows the therapist to (a) tune in to the client's experience who is, supposedly, fixated in paranoid-schizoid position (b) makes the symbiosis state possible (H Searles' view of progression in therapy with the psychotic). This is similar or relevant to Participant 2 description of sense of 'catastrophe'? Explains this experience as stimulation of one's psychotic layers. Does it have to do with personal experience of the therapist, his or her difficulties in development (fixations at paranoid-schizoid position) or early exposure to psychotic material, for example family members (not necessarily psychotic, but borderline, psychic etc.) or chaotic

Emergent themes	Original transcript	Exploratory comments
		upbringing, the parents 'driving the child mad'? True for this participant, but further investigation needed.
Feeling in control while her perceptions are impaired as empathy serves as an anchor to therapist's reality Empathic response to client's heart-breaking suffering	Aaam, but and **I don't find that alarming, I don't find that frightening. As I said on an emotional level the thing I would usually most be feeling at times like that would be you know, heart-break, you know, you feel sort of heart-broken for how, for what they are experiencing** because you know they are, these are people who, if I think about that client that I was talking just there, thinking about just now, you know, when he's in those, in those kind of delusional states he, he, he is a complete [inaudible] and he's hearing voices and having all sorts of kind of experiences that are telling him, you know, that he is a scum of the earth, you know, everybody hates him, he will be hearing about the plans that people are discussing about what to do with him, about what his fate would be and it goes along with a very, very depressed mood, because obviously [*R: not surprisingly*] yeah, exactly, exactly, I mean some clients obviously have very angry response to that but he doesn't. He has a very depressed resigned attitude to it and I suppose that is why it is so heart-breaking you know that he thinks, that, he's telling me this in such a way that he's, you know, that this is his, this is the way it is, you know, I'm the scum of the earth, they've explained to me that I'm the scum of the earth, you know, I've got to leave my flat and in the past of course he's done some really dangerous things like, well dangerous, I mean making himself very vulnerable because these voices had told him, for example, in the middle of winter to leave his house and just walk out of London in the country side and they told	Regards this experience as normal, on emotional level experiencing empathy Gives example of how client's suffering is heart-breaking for her to hear. Helplessness and inability to change those painful experiences of the client is hear-breaking. The resigned attitude, no motivation or hope is heart-breaking Disturbing client material

Emergent themes	Original transcript	Exploratory comments
	him things like to take all his clothes off so he would be walking naked in the winter. Once, this was before I'd known him but they told him to urinate in the street and to get on his hands and knees and leak it. So you know, in a situation like that emotionally you just feel very, I just feel, you, you know, heart-breaking for him. Sometimes,	Compassion
	R: Can I just interrupt you [P: yeah]*, would it be different when you have a client who is not psychotic and who has reported self-harming? Would you feel differently in those two situations?* [P: It's a good question] *R: I suppose the voices is self-punishment [*yeah, exactly] *in an attempt to become better, I suppose, if he punished himself enough.*	Probing how this experience is different from working with self-harmers hoping by this comparison to extrapolate something specific to working with schizophrenia
Self-harm in working with schizophrenia elicits empathy in the therapist whereas with non-psychotic clients it alienates the therapist	Yeah, it's a very good point, that certainly the self-harming scenario is the same thing it's just that *[R: but the way you experience it, is it different?]* The way I experience it, you see I do work and have worked for a lot of years with self-harmers they, God, that's such a good question, I never thought of that before, they don't get me emotionally the same way that someone like he engages my emotions. Why is that? … I don't know why that is. In a funny sort of a way maybe it's because the, it's always a danger isn't it with self-harm with people who use self-harm as a coping mechanisms that, first self-harming gets in the way all the time aam, and maybe that way, maybe that's why it. If self-harm is on the agenda in the session it almost acts as a kind of emotional barrier for me, I would certainly have to fight very hard to get it out of the way to get it to you know, sort of, you know, experientially feel the same level of empathy that for example I felt, I feel with that particular client that I was talking about. That can	Compares her experience of psychotic self-harm and non-psychotic self-harm. Self-harm gets in the way, yet it doesn't when working with psychotic clients. Is it this child-like, helpless, out of control position of the psychotic which is eliciting empathy in the therapist whereas with self-harmers the therapist assumes client's control over actions. Does the therapist experience

Emergent themes	Original transcript	Exploratory comments
	be countertransferential as well, you know, that's something that's they are experiencing as a way to distance themselves from their emotions and I am getting that as well. I mean of course that's not to say that other times when we were talking more let's say slightly with a, we were talking without the distraction of the self-harm that I wouldn't feel empathy very sort of full on but where the self-harming is on the table is in front of us it is somehow acts as more as a kind of a barrier in a way. In a way that with psychosis it doesn't, aah, yeah [*pause*].	this as clients' conscious desire to break therapeutic alliance and sabotage treatment - thus responding to it with emotional distance? In the psychotic the sabotaging part of the psyche is split off and feels like a separate entity to both the client and the therapist? It becomes a third force that both therapist and the observing ego of the client try to fight. In non-psychotic there is no such split, thus, perhaps client's resistance to change is pushing the therapist away. The self-harmer places an unspoken demand for compassion and quick fix which contributes to eliciting anger and alienation in the therapist. Plus, countertransference reaction where therapists' feelings are numb. The difference might be that psychotic person is not consciously in control over the voices' order to hurt oneself. Illusion that the self-harmer is in control.
	R: What do you think you can achieve with psychotic clients? Do you feel there are limitations to what you can offer?	Moving on to next question in the interview schedule

Emergent themes	Original transcript	Exploratory comments
Difficulty of thinking about limitations in working with clients with schizophrenia Risk (to self or others) as a limitation in working with schizophrenia	Aam, [*pause*] aaam, surely I must say yes to that question but I am struggling to think what they are. I suppose in practice, in reality the, the only tangible barrier, I shouldn't say the only as I might think of something else, but the first thing that springs to mind would be possibly the only thing that would be a serious limitation would be if there was very, very serious risk associated with it. For example, that client I was telling you right at the beginning who was, not right at the beginning but the one who was very thought disordered where I kind of was completely confused and went and, he told me as part of that initial consultation that last, that the last time he had therapy was at the, I think it was at the Tavistock and aam, this took a little piecing together because he was so thought disordered	Can't immediately think of a limitation, is there an underlying belief that the therapeutic work with schizophrenia is essentially like therapy with any other client group? Symptoms do not present as limitation? Risk to client's life is seen as a serious limitation and a barrier in therapeutic progress Brings a clinical example to clarify the point on risk
	but, he told me that the last therapy he'd had was at Tavistock and he was trying to tell me something about the therapist, who by the sound of it was very sort of mainstream psychodynamic, very kind of blank screen, and who didn't kind of interact with him very much and he said that he was so disturbed, he didn't use that word, he used some other word but, he was so disturbed that when he came out, came out of that session that he cut off his own testicle. That, actually, I just mentioned to you that it turns out that that wasn't actually true, it wasn't literally true. It for him and the way he experienced it, I think it was metaphorically true, he must have felt really sort of castrated by that sort of, you know, what is that term that they use, is it abstinence, you know the psychodynamic people that won't put anything in or and this particular client aaam, yeah, I suppose that's kind of, that's it, he felt he was castrated it was excruciating for him but but anyway	Risk of self-injury presents a limitation in therapy. Or is it a limitation of the setting - private practice work with schizophrenia? The nature of private practice work is that the psychotherapist is essentially on her own and dealing with serious risk issues is difficult. On the other hand long-term inpatient treatment is rare.

Emergent themes	Original transcript	Exploratory comments
	that when he told me that aam, when I sort of pieced it together aam, that's a limitation. So what I had to do was aam, say to him, well I'd already said this actually at the beginning, I'd already sort of set it up of when we it's just going to be an assessment and that we would, you know, we would a sort of consultation. He, he was very, extremely intelligent gentleman and he's been through the system a lot, he knows all the ..., he knew all the ..., you know the idea of coming for an assessment, you know. You know conferring with other professionals in his care and all of that so, and we'd already said that that what'd happen but I reminded him of it at the end and so in practical terms that was potentially a limitation obviously because, you know, he is telling me that whether that turned out to be literally true or not, in fact I didn't know whether it was, but that's, that's a serious risk issue.	Need to manage risk
Ways of managing risk issue in private practice	And aam, but even that to be honest I wouldn't say it was completely, it didn't mean that therapy was a complete no-no because with him, he was clearly linked in with other professionals so in a case like that I could, you know, in theory I could speak to his, you know, psychiatrist, I could speak to his CPN, I think he had, social worker, he was also in supported accommodation and I could've spoken with his support workers so if I were going to go ahead with that piece of work with those risk issues there I've got that safety net but there are other clients that I see that I, I don't communicate with their, if they have professionals which most of them do, aaam, I don't communicate with them unless there is an absolute dire emergency so, so that would be a limitation, that would be an example of a possible limitation. So let's say if somebody came along, presented a serious	Participant thinks that this limitation of dealing with risk can be overcome with the support of other professionals. Without external support for both therapist and client in cases of serious

Emergent themes	Original transcript	Exploratory comments
	risk issue and for, you know, reasons of lack of external support for me as well as them, I couldn't in theory go ahead with the work.	risk psychotherapy with psychotic clients wouldn't be possible
	R: Do you think schizophrenia-psychosis can be cured?	Hoping to prompt the participant to think about other limitations, perhaps conceptual and theoretical as well as practical. I used here both 'schizophrenia' and 'psychosis' because she used these terms interchangeably throughout the interview
Recovery as an objective of therapy Optimistic and confident position in her ability to help and ability of most clients to benefit from therapy	I tend not to think of, in terms of cure, but the, the most sort of recent concept of recovery where you are not thinking in terms of the clinical recovery as in the person will have no symptoms they won't need to take any medication, you know, do not need any support but more of **the recovery where the person may continue to have some symptoms or some unusual experiences but their sort of condition or their predicament doesn't dominate their entire life and they can have a, you know, a reasonable, a life worth living. That type of recovery - yes**. **That is 100% achievable, doesn't mean it is going to be achievable for every single individual but it is definitely achievable and I go in to every piece of work on that basis**. Aaam	Symptom free life is judged unrealistic Cure versus recovery Participant holds a very optimistic view of recovery and thus values psychotherapeutic work with people with schizophrenia
	R: What do you get out of this work? [P: laughs] *You said you find this group of clients fascinating, interesting, what attracts you to this*	

Emergent themes	Original transcript	Exploratory comments
	field, what's in it for you?	
Impact of personal life history of the therapist on her work	I could answer that on many, many levels. I think on one level it's about me and it's about my life history because my mother had mental health problems but I was too young and the sort of system of care around, I am 51 now so the, the, the kind of system of care that is springing into place now if somebody was quite severely unwell and had children is very different to the one that was around when I was younger, aaam, so I think that. I mean she didn't have a diagnosis of schizophrenia or anything like that, I absolutely don't know, nobody ever, no professional ever had a conversation with me about what was the matter with my mom. Aam, and we didn't even, I think we were so traumatised in the family, there were 4 of us, 4 children and certainly me and my sister were very close. We never ever spoke about it, I mean we spoke about rough edges of it like if she was taken to hospital or when you know, she made suicide attempts or things like that but we never actually spoke about it. So, I think, I mean she completely recovered now, aam, but I think on one level there, **there was an unresolved need to get control of this situation, understand it, find or maybe discover some way to aaam, to help**. Aam, **because obviously I was only a child I hadn't way to help so I just used to, sort of get in there and try to be with her**, aaam so I think on one level that is part of what drew me into this. On another level, but not unconnected to the first level is the fact that I ended up working, the first sort of serious work I did as an adult that I kind of really stuck with was in mental health - support work. Aaam, and so, you, you see what I mean not unconnected, but I then sort of had a different angle on this because then **I'm then not just aaam, being**	Relates her motivation to work with schizophrenia to her own life story Sounds angry that professionals in the past let her down and didn't support her Lack of communication in the family about mental illness Working with psychotic clients feeds the unresolved need to get control of this situation, understand it and find a way to help? Repetition compulsion? An attempt to cure old wounds, working in this field offers the participant an opportunity to transform herself (Maroda on choosing to work with more severely disturbed clients, a reflection of past disturbance of the therapist: the more damaged the
Disappointment with the mental health system		
Need to master past trauma and sense of helplessness as a motivating force in desire to help clients in the present		
Mastery over helplessness		

Emergent themes	Original transcript	Exploratory comments
	with people with this sort of extreme states of mind but I am learning ways to help people or to make responses or, you know, that whole kind of professional side of it.	therapist the more severely damaged group of clients he or she will chose to work with. Seen as a healing journey.) or (clients with schizophrenia, are the most damaged people and will do their best to help the therapist in the hope that a 'cured' therapist will be better able to help them: H Searls) Desire to help people in distress. Sense of control over the situation as opposed to total lack of control and ability to help when she was a child.
Enjoying the work Drawn to working with schizophrenia and fascinated by it	Aaam, and I think I became aware not that long after I got into that work that I really preferred working with psychotic people and people with schizophrenia and all that kind of thing. And at least **part of why I liked it was because I wasn't scared of it, I didn't, it didn't feel that sort of unfamiliar to me**. I don't remember particularly sort of thinking, you know, making the connection explicitly but **I do remember just sort of being kind of drawn to it, fascinated by it**.	Natural desire and ability to work in the field of severe mental health. This work gives her something very important; thus, is the most attractive out of all other client groups she worked with. Does not consider this kind of work alien, unfamiliar. No fear. Feeling in control. Drawn to working with schizophrenia, fascination and curiosity
	and sometimes I used to what actually was a bit of a problem if you work in a mental health system and I still do sometimes have to watch	Non pathologising, existential perspective on 'madness'

Emergent themes	Original transcript	Exploratory comments
Normalising work with schizophrenia and client's experiences	out for this even all these years later. It's not, not, not seeing, [*laughs*] this sounds so ridiculous what I'm going to say, but not really seeing what the problem is. I can see that they are in these unusual mental states and amm, maybe, you know, they are delusional or unusual believes and so on and so forth but when I am actually interacting with them I am not feeling like I'm interacting with somebody that is on a different planet, I just kind of, I just feel like and maybe it's me who is being delusional, I really don't know, I don't, I'm not really that bothered actually about it, but aaam, I don't, I don't feel like it, and I am thinking particularly, the reason I started saying this is because I am thinking of actually the sort of the support and the clinical context but I sort of, you could describe that as a problem but when I am interacting with them **I couldn't see what the problem was.** Yeah, I can say they are really, you know, barmy, I can see they're really mad but that didn't seem to me like any kind of problem because I just communicate just like I would with anybody else. aaam, yeah, anyway, so, anyway that could be a problem because people can, particularly if you're working in mental health system, they don't like people to get any more mad than they are already are so you're supposed to watch out for that and you're supposed to obviously, you know, be very sort of clinical about it and report back and you know, and so on and so forth if their mental state is deteriorating or I've discovered this new symptom they've got or whatever. So this could be problematic because I wouldn't necessarily, unless someone was terribly, terribly distressed or unless somebody was posing some kind of risk to themselves or somebo...., or another person, I wouldn't particularly see what the problem was. Amm, now I think probably now that I very deliberately and	The interaction, the experience is 'normal' Normality and ability to see the person behind the symptoms. Aware that in the clinical context this would not be accepted Sounds like the participant is disappointed with the medical model (thus abandoned working within the medical profession), holds her beliefs back because she feels that medical staff are too focused on the diagnosis, symptomatology and pathology. Acceptant of client's experience Disappointment with mental health system
Criticism of medical model for pathologising clients		

Emergent themes	Original transcript	Exploratory comments
	consciously got out of the mental health system now it's quite an asset because it's part of I think being able to sort of aaam, I don't know, experientially enter into the client's world in a sense.	Ability to emotionally connect with clients
	R: If you were to give advice to a therapist who is working with clients with schizophrenia what would it be?	Moving on to next question in the interview schedule
Need for grounding: Importance of schizophrenia specific supervision Need for grounding: Importance of theory Work is described as 'utter unbridle chaos' Promoting psychotherapy with schizophrenia	I would say **you've got to have really, really top quality supervision with somebody who has worked intensely and intensively with people in those mental states because you need that grounding**, you need aaaam, you need somebody to do for you what you are doing for the client and that obviously that goes without saying for all types of therapy but in this type of work it is really, really important that you do that so I would say you've got to have really strong supervision I would also say that whether you end up wholly subscribing to them or not you really need to know do your spade work in terms of theories around psychosis so. For example, although I would, I would never describe myself in any way as a Kleinian worker and I don't, I wouldn't want to work in that way for all different sorts of reasons, but that particular sort of framework for understanding what's happening in the psychotic mind is really, really helpful and I think given the fact that **you are often working in utter unbridle chaos you need a really strong theory or a set of really strong theories to be able to go back and make sense of what's going on.** Aamm, so that's what I'd say is the other really important thing. Aaam, what else would I say is important? Well, you know, I don't really sort of know if it's an advice thing, but I think **that I would sort or really, really want to encourage therapists to do this**	Highlighting the need of good supervision. Importance of support for the therapist, need for grounding Need for a supervisor who is experienced in the field, the supervisor without this type of experience wouldn't be able to understand and support in the same way. Importance of theoretical foundation - the need to be intellectually in control, grounded by theory to counteract the chaos of the psychotic client's state. Once pulled to the extreme end of the spectrum described above, there is a need to be firmly in touch with the reality via theory or supervision Finds work of Melanie Klein useful

Emergent themes	Original transcript	Exploratory comments
Practical difficulties in working with schizophrenia in private practice: Lack training on psychosis Client's low income as a practical difficulty in private practice	**type of work because it is so needed. Aaam, and there are lots and lots of barriers and hurdles, you know, for individual therapists that might sort of think, you know, maybe could I? I mean for one thing the whole of my 4-5 years of training we never had any training about working with psychosis it wasn't even on the agenda** [*R: so do we*] right, **I thought that was really, really wrong, I did my Master's dissertation on working with psychosis but I did it because I was interested not because it was something on the curriculum.** So that's one thing that therapists have got, the hurdle the therapist have got to get over and another one I am afraid is fees, because you can't, realistically, you can't work not sort or wholeheartedly with psychotic clients if you want to charge sky-high fees you, it just can't be done because the vast majority of these clients are, can't work and so they are living on benefits and so you've got to be prepared to work for you know, not ac.., I mean, just to give you an example what a lot of my clients do is they pay for their therapy out of their DLA benefits aaaam, so you know, you've got to charge a relatively low fee, you know somewhere between maybe the sort of 30-35-40 mark, you can't if you want to keep them and if you want to give then a shot of it you've got to be willing to lower your fees. But yeah, that's what I would I would really encourage people to do even though it's a, they've got some hurdles to get over.	Need/lack of therapists working with psychosis Highlights lack of training, sounds disappointed and annoyed that this area of training was lacking in her training Practical issue - limitation in private practice, need to adjust the fee to client's low income.
	R: We went through all of my questions [P: ok] *but was there anything else you thought I might ask and I didn't?*	
	Aaam, no, well I mean I say that because I was racking my brain what	

Emergent themes	Original transcript	Exploratory comments
Views research on schizophrenia as very important	you were going to ask me and feeling sort of worked up a bit I might not be able to think of anything useful to say. But I, very kindly you've just kind of suggested that it's just about what my experience is so here we are I've just given it to you but aaaam, no I don't really have any question except to being very encouraging to you. I was just saying to a client just before I met you I said I've got to keep an eye on the time because I am meeting someone. But this time is me being interviewed and she asked me what I'd be interviewed about and I said this is a woman who is doing a research project which is loosely, I am afraid I didn't remember exactly what the title was, but it is loosely about therapists working with psychosis and aaam, and I said, and she said 'oh great it's good' because she's got schizoaffective disorder so she hears voices and things like that and she said 'oh great it's really good, really good that people are doing research on that' and I said to her that's why I agreed to do it because you do occasionally get asked to participate in, I know all research is important but **I wouldn't always make the time to do it but I wanted to make time to this because it's really, really important what you are doing**, you know, so, that's not a question	Thinks that there is a need for research in the field of working with schizophrenia. Sounds like she wants more people to be working in the field, to promote is and
	R: Thank you very much for participating	
	My pleasure absolutely. Funnily enough you gave me some really good things to think about	

PARTICIPANT 4 – JAMES
Interpretative Phenomenological Analysis of the interview transcript

R: Text – stands for researcher's interventions
Bold – Notable quotes, used in the results section for illustration of the themes
Exploratory comments: Descriptive comments (normal text), Linguistic comments (*italic*), Conceptual comments (<u>underlined</u>)
Square brackets and italic within the transcript – descriptions of non-verbal communication and background sounds

Emergent themes	Original transcript	Exploratory comments
	So maybe I'll let you know a little bit about my background and the contexts that I worked with patients with schizophrenia. I aamm, basically, I've done my psychology degree in Britain and then went back to Germany to do my [*R: You are German?*] yeah, postgraduate training in psychotherapy and the focus was on cognitive behavioural therapy which was like a five year postgraduate training after my MA in psychology that I've done here. So the first time I actually encountered work with patients who suffer from schizophrenia was when I, before my studies I did like a social year abroad, I lived in Israel for a year and worked with people who had mental health issues and there were a few of them who had schizophrenia. I remember one client in particular who, it was drug induced, then he had a chronic development and he had just, you know, continuously some symptoms like hallucinations and delusions. So I remember he was the first person I met I was about 19.	Comments on his training: BSc and MA in Psychology – UK qualification 5 year postgraduate psychotherapy course in Germany *Uses words like 'suffers' from schizophrenia*
	R: What was it like?	
Fascination with the disorder and with the people who suffer from it	It was really interesting because he was a very interesting aaam, fascinating person, he was very into art, he was very, I really liked him and I remember then being for the first time fascinated by that disorder by people who suffer from it. And then I read a little about it during my degree, during my first degree in Britain, aaam, I read	*'Interesting' and 'fascinated by the person and the disorder'*. New experience? Curiosity?

Emergent themes	Original transcript	Exploratory comments
Influence of R.D. Laing on understanding schizophrenia	bit R. D. Laing, I don't know if you know about him [*R: hmmm*] and really found all quite interesting and fascinating and, and when I did my postgraduate training in Germany, amm, I started basically working with some patients in an outpatient setting. So I saw, I remember 2 patients who I saw every week basically for 60 sessions, about 60 sessions, patients who suffered from schizophrenia, paranoid schizophrenia, and then I also started working in a project where people live and also get some therapy, so this was more a project for people who have like a chronic developmental schizophrenia, so chronically hearing voices, chronically having a lot of negative symptoms, chronically to the extent where they need some support basically living. So they lived in their own flats but they were able to come and see a colleague and me basically every day for group therapy or for one to one sessions. So and then I also worked with a few patients here at the hospital, again either in a one to one setting or in a group setting. And then I also worked in Germany a part from the seeing some schizophrenic patients in a one to one outpatient setting and the project that I just described I also run a closed group with a colleague in corporation with a big hospital in Berlin which was a closed group for outpatients who suffered from, specifically from schizophrenia. So I am just explaining to you all this to let you know that basically I worked with different, in all these different settings, so more in a community based setting where they actually live, in a, you know, as a therapist with outpatients, in a closed group and in an open group here and what I always find is and I don't know how, I think it's very scientifically aaam, explainable but I find very often the patients I work with who suffer from schizophrenia**, I find very, something**	Describes his experience of working in different settings: one to one, group – both closed and open groups. Hospital and community housing projects *Uses a word 'suffer' very often* 'Something very particular' –
Fascination with the		

Emergent themes	Original transcript	Exploratory comments
sensitivity and vulnerability of this client group Respect for vulnerability – desire to protect the clients from being shamed Fulfilling work People diagnosed with schizophrenia are hardworking clients	**very particular about them, there is something very different about them and I often find, I am often very fascinated by their sensitivity, I find them very sensitive as a, in terms of their personality and I often find that there is a lot of, they are quite vulnerable and, and, and that what I think hooks me a little bit is this**, you know, I think when you managed to build up a good therapeutic relationship with them and if you, I think you have to be very careful not to shaming them, I think there is such a huge level of shame for them being diagnosed with it, I think there is a huge stigma in society about it, in families I mean in terms of the patient, parents' reactions or [*inaudible*] in the family and I **find if you manage to get a good rapport, good therapeutic relationship, good alliance then I think the work is extremely fulfilling as a therapist, I find it really fulfilling because actually they are quite willing to work quite closely with you**, I, I feel	mystery? Fascination with the mystery? Participant finds their sensitivity and vulnerability very appealing –'that … hooks me'. I wonder whether he identifies with this vulnerability. Sensitive to their vulnerability and fear of being shamed Protectiveness Good therapeutic alliance is fulfilling Work is fulfilling as clients are highly motivated to work – makes the participant feel valuable, needed and important?
	R: And you use cognitive behavioural therapy	Clarifying in what modality the participant works. This question, however, took him away from describing his experience
Meaning making process as a crucial part of therapy	Yes, so basically, as I said my training is in psychotherapy but the focus was on CBT, it was CBT so I am a cognitive behavioural therapist, aamm, so what I did with them usually is, you know, very typical CBT aspects like psycho-education, amm, but what I found really interesting, I think it is really crucial for them apart from the obvious psycho-education, stress model and all that to get a real understanding of their own illness, their own disorder, why did I develop this amm, what does is mean, to get a meaning for it as well.	Importance to explore with client the meanings they attribute to their experiences (Similar to finding in 'Models of Madness' book chapter on client's

Emergent themes	Original transcript	Exploratory comments
Empathy	So I think it often takes a huge amount of the therapy, of the therapy and I also think it is really important to amm, to process what happened because often when they, you know when they first encounter psychotic symptoms it's hugely unsettin.., unsetting.., unsettling for them it is hugely amm, you know, a sense of not being able to trust your own perception, you know, a sense of not trusting others if, you know, if they are paranoid amm, so I think, I think just that, just processing that, I think it is really important that one does that. Sometimes just even before you start you know explaining, giving psycho-education or explain negative symptoms I think first of all I think it is really important to see where they are in terms of shame, in terms of feeling unsettled, in terms of feeling stigmatised ammm, in terms of often thinking that you know that they won't have a life that they may be had in mind because of their disorder, in terms of children or work or you know, I mean	experiences) The participant is open to processing emotions and exploring meaning despite the fact that he is a CBT therapist. I wonder whether this is because he trained in Germany where CBT is more than a '6/12 weeks fix' approach. 60 sessions – long term work. Participant is empathic towards the difficult experiences of his clients Sees the establishment of trust and building therapeutic relationship as a foundation Acknowledgment of client's difficulties and exploring existential aspects of their suffering
	R: What is it like for you?	
Enjoyment in finding meaning together Rewarding experience Desire to rescue as a response to client's vulnerability	Amm, I really enjoy that, **I really enjoy that part where you together make sense of it and together, amm, and if you are able as a therapist to take away a little bit of that, aaam, shame and that anxiety they feel, often in my experience I find it hugely rewarding**	Enjoyment – taking away shame and anxiety is rewarding, I wonder whether it satisfies within the participant the desire to rescue. Gives the participant sense of potency? Make sense together? I wonder what does it clarify for the participant? His need to make sense? To solve the

Emergent themes	Original transcript	Exploratory comments
		‘mystery’ that he is fascinated with?
	R: What do you notice about your reactions? [to them?] *mmm, as perhaps, opposed to your other clients you might have?*	
Protectiveness as a response to client’s vulnerability Working at a slower pace as a way of protecting client’s self esteem	Ammm, as I said earlier I think **I notice in myself that I am a little bit more protective of them**, I am little bit more slow, I am slower with them, I am a little bit more, I think in terms of, you know, delusions and jumping to conclusions, which is you know often what they do, if they, you know, delusional. For example, I try to make sure that there isn’t any ambivalence so if I sense their, if they maybe haven’t understood what I said or they are interpreting in a different way I think I would make extra sure that I explain it or pick it up again or amm, whereas with someone who suffers from depression or anxiety	Protective of the clients Slower: careful not to shame them, not to elicit thoughts like ‘I don’t understand’ and therefore feeling stupid – slower pace as a way of protecting client’s self esteem Need to adapt to the vulnerability, creative application of the approach in which the participant was trained. Need to care for the clients
	R: So you’re careful not to create further delusions?	Testing my understanding of what was said
Parental role looking after the clients Providing extra care	Yes, yes, and, you know, trying to be quite straightforward, I mean **it’s something you always try to do as a therapist, you know, to be authentic, straightforward, ammm, you know, as honest as possible, but I think with them I feel I have to do it even more in order not to give them any amm, not to encourage any jumping to conclusions** or delusional ammm	Taking extra care in being straightforward, authentic and honest to avoid the development of further delusions – adopting or responding to clients’ predicament. I wonder whether this extra care is also ‘extra work’, however, it sounds like the participant does not experience it in this way, rather he enjoys this ‘parental’ role.
	R: So there is a need to protect	Testing my understanding of what was said
Finding balance between	A little bit, yeah, I think so. Ammm, at the same time though I think	Danger of overprotecting

Emergent themes	Original transcript	Exploratory comments
'extra care' and not overprotecting Limitations of the training Training message: infantilising the client Protectiveness Danger of overprotecting	**it's important you know not to overprotect because I think that is very much their experience with their families usually anyway** you know and think you know, I think it is also **quite a neglected group in therapy, in terms of our training** for example, I mean very often there were messages from, in my training like, you know, when they taught us certain techniques or certain tools there was also they'd add 'be careful with psychotic patients and, you know, don't do that with psychotic patients or'. So I think what **I worry about that there is a sense of being overprotective and overly careful so I think you have to find a balance**, excuse me [*hick ups*] not to on the one hand yes, being protective and I think it's very much my reaction to them, but on the other hand also being very resource oriented so, orientated with them. So, what do they have? What strengths and qualities do they still have? amm, and also supporting them when it comes to their parents being overprotective, I had this recently with a young patient who had psychotic, had psychotic episode basically drug induced and he got much better and in the end he, he didn't have, he just had a few negative symptoms but he didn't hear any voices anymore and, and for him it was a huge issue because he was, he was in his early twenties, you know, about to leave home to, and to you know, to you know, start life as a grown up and I think that for him it was a huge problem that his parents were extremely protective, very worried obviously. So in our therapy it was very important for me not to do that, because that's what he gets anyway. So really to get the sense of yeah ok, be careful but, you know, you can do this and that and these things and I do trust you and I do trust your abilities and your aamm. Does it make sense to you?	Neglected client group – psychotherapy training does not focus on clients with schizophrenia. Taught techniques are often presented as unsuitable or ineffective with clients with schizophrenia thus leaving a practitioner unprepared for working with this client group? Participant reaction - protectiveness This gives a message that clients with schizophrenia are too vulnerable and thus infantilised? Participant is aware of the danger of overprotecting the client. Thus the need to strengthen their ego, resource oriented approach – paternal role? Illustrates the way he worked around his overprotectiveness with one client

Emergent themes	Original transcript	Exploratory comments
	R: It does, yeah	
The need to creatively adjust techniques to client's vulnerability and limitations	So, I think you have to be careful too. And I think the same with mindfulness, often they say don't do mindfulness with and I think of course don't do it with someone who's acutely psychotic, yeah, for example I wouldn't ask them to close their eyes and do mindfulness exercise or whatever, I think you can do you know like, like low key version of it, you know, you can ask them to leave their eyes open and just you know maybe just quickly check how they are feeling in terms of body, just a very brief breathing exercise or you know, I think you can adopt a little bit the tools that you have as a therapist	I get a general sense that he feels there is more hope in working with psychotic patients than it was acknowledged in his training. Constant caution from training institution seemed to make these patients sound untreatable, beyond technique and 'frighten' therapists away. Participant emphasises that with a bit of creativity those techniques can be adopted and used effectively and there is no fear in the work.
	R: Did you have clients who had an acute psychotic episode and had to be admitted?	
Targeting compliance issues Empowering clients to address their needs with	Amm, yeah, yeah, they were, there was one outpatient I worked with who I saw every week for one session and she became very, very delusional, amm, thinking there was a paedophile living next to her and therefore she was abused and it became to an extend where she, she admitted herself. So that's another thing I really think for example compliance when it comes to medication, compliance when it comes to amm, coming to therapy sometimes, I think these are all things that you have to discuss with them very openly and if they struggle with compliance on occasion really ask about the reasons for it and give them a sense that, they have a right to discuss this with their consultant for example. And they are not helpless, they are not amm, amm, without some influence, without you know, the	Compliance with medication and attending therapy as necessary topics to be discussed in therapy Helping clients to voice their needs, become more assertive -

Emergent themes	Original transcript	Exploratory comments
their consultant	possibility to say something. And with her when she became very, she stopped taking her medication, she became very, very unwell and she called me a few times between sessions and said it was very bad and she was very anxious and with her, you know, it was really about negotiating, ok, so let's look at the option of admitting yourself, you know, what your concerns what can be beneficial about it, amm, so she was admitted and then she was admitted for a few weeks and came out later but I think it is also import as a, if you work in an outpatient setting there is always [*inaudible*] to be even more, to be there for them and to sort of go with them through that phase, if that makes sense, to say 'ok, come on, what could be an advantage of that and, you know, if you do that for a few weeks maybe it's safer for you, maybe it's a chance to take advantage of that situation that you are experiencing, it's so difficult at the moment and then I'm going to be there once you're back, I am still going to see you. So there was someone who was admitted and there were one or two patients in the project where I worked at this sort of project where they lived and also saw for therapeutic support and sometimes when they deteriorated or amm, got worse then they would go, get admitted basically. Yeah	strengthening the ego Offering support, giving a client a sense that the situation is manageable (going to hospital) Gives a technical description of what he did rather how he experienced it *Shows how much he cares about his clients, particularly the tone of his voice and intonation*
Caring and protective towards clients		
	R: How did you feel about it?	This question is slightly inconsistent with the question I asked other participants: 'What was it like ...'. Here, the question requires a feeling description as an answer, too leading
	Amm, I think you have to be, I think if there is any chance to not to do it, if there is any chance to, you know, if, you know, if them seeing you once a week is enough or if you feel though, you know,	

Emergent themes	Original transcript	Exploratory comments
	there is enough support, external support with, you know, their families or friends, and if there isn't threat or, or, then I think it's ok, you know, I think it's something you have to judge, but when you feel ok, now this is getting too overwhelming for them, and too stressful for them because they are constantly, they are not leaving their house anymore, they are not leaving their flat anymore, they're constantly in a state of anxiety and paranoia, then I think it's really important that they, you know, get admitted, I think, you know, I think that again, when I worked in a project I ensured that I visited them for example, you know, once a week, so they didn't feel sort of locked away, amm, so I think it's a lot about relationship, saying right, we're still here or I'm still there or if it's outpatient you know to say right we can talk on the phone maybe once a week when you're in hospital ammm so I think, I feel alright about it, I feel alright about it, I think it can be beneficial, I think it can be helpful, I think sometimes it is the best thing, you know, to take yourself away from that situation and hopefully. Sometimes they would feel more safe, ammm, if they are in the, in the, on the ward, you know	*Provides a rational explanation of why it might be beneficial for clients to be admitted to hospital* *However, he did not describe his own response to it, just says 'I feel alright about it'. Does that mean this kind of situation does not elicit any particular feeling/reaction for this participant? Or it reflects a very cognitive, rational and intellectual style of the participant?*
	R: What do you think can be achieved with this client group, do you believe in cure or whether there are limitations to the work you can do?	
Confidence in curative potential of psychotherapy with schizophrenia	**I think an awful lot can be achieved, I think a part from you know getting them understanding their disorder, getting to understanding of what happened to them processing potentially very difficult feelings they had about their first admission because probably**, I often notice that first admission can be actually quite dramatic. When they are at the stage of not knowing what's happening with them, not understanding what's going on for them	Believes that 'an awful lot can be achieved' - sounds hopeful Uses very cognitive language - 'understanding', 'I think' a lot

Emergent themes	Original transcript	Exploratory comments
	and then suddenly being, you know, feeling a huge sense of loss of control, being put in a hospital because their parents or their you know their, or someone says, you have to go to hospital, so I think processing that really, really important amm, so I think all these things can be achieved and I think then, obviously on a symptom level later on in **therapy I think you can work on things like you know, behavioural activation, aaam, structure, building a structure is very important, because often they** might not work or they might only work a few hours a week or amm, so, and they are often **very withdrawn**, that's another thing, real lack of, I found, depending on, but with more chronically I think they're often quite withdrawn, lack of contacts, so I think, building up social network, building up activities that they enjoy or they enjoyed, aaam, I think that is really important. **When it comes to delusions, I think there is a lot you can do** from a CBT perspective in terms of you know the ABC model, you know Beck uses it for, you know, uses is for, uses it as well, I mean and Lincoln did some work on it, there are many people who, who came up with CBT, a CBT approach to it. So I think it's something you can use as well. I even think, **making sense of the content of the hallucinations is very important as well, because there is always a link to you know, their biography or their bigger themes**, or their schemas, ammm, when we think about schema therapy for example, so I think, **I think there is an awful lot that can be achieved**. I also think something I've mentioned is drug taking; self-medication with cannabis or alcohol I think is very common. So also looking at that and try to identify healthier behaviour, alternative behaviours like it is about, you know, not hearing the voices anymore or not feeling anxious	Points out the difficult feelings around first admission Importance of processing the feelings around the experiences of being admitted for the first time Working on managing the symptoms - realistic goal of CBT Importance of behavioural activation, structure, building a social network Working on delusions as a realistic goal of CBT Making sense of the content of the hallucinations as part of schema therapy Repeats a few times that a lot can be achieved, sounds hopeful and confident (in this passage he listed a number of realistic goals) Helping a client to identify healthy

Emergent themes	Original transcript	Exploratory comments
	anymore, what can they do instead, instead of smoking weed, or you know, or drinking. So, I think there is awful lot that can be achieved with them	coping strategies
	R: Any limitations you can think of?	
Struggling to see limitations Being realistic - Cure versus recovery The need for therapist to accept that not all clients can lead a symptom free life The need for the therapist to be patient Acceptance and finding meaning as a realistic goal of therapy The differences of CBT practice Germany and the UK	Ammm, I wouldn't say limitations but I think you have to also be realistic. So, so a patient might, I am thinking now about the patient at the project who had quite chronic development of it and then were also the limitation of ammm, excepting that there may be relapses or that amm, it's someone who will always more or less, you know, have some symptoms and it's about finding a way to live with them. Ammm, and not having maybe the expectation necessarily that they will be completely symptom free. For yourself as a therapist but also for them sometimes. Being patient I think is really important for them again, having a sense it might take a while, again, also for you as a therapist. And I think [*R: you, the therapist need to be patient?*] yeah, yeah, that it takes a while, that you know maybe it's just going to be about acceptance, that's just going to be about, for long term therapy about making sense of what happened and not so much, in CBT sometimes I think it can be the danger that you, you know, with depression and anxiety you do this, and this, and this and the symptoms are gone and all of this in 10 session or something, you know. Ammm, and I think, in Germany it was different because we had much more time, so I think it's something different here in Britain in terms of being more, I get the sense there is a bit more, time limit. So, for example, when I work with outpatients in the, in the one to one setting I had about 60 sessions, I mean, that is a lot. When I did the closed group ammm, with outpatients in the hospital in Germany we had basically two one to ones for each patient and	Does not accept the word 'limitations' - does not think there are any? Similar to Participant 3 who, at first, could not think of limitations. Being realistic - Cure versus recovery The importance of acceptance for both the client and the therapist Not sure whether he is he implying his view of schizophrenia as an incurable condition? Persistence of symptoms that may never go away ('Hope and expectation' paper is relevant here) Patience (Participant 2 - example with the pigeon) Challenges 'quick fix' which is often implied by CBT models of anxiety and depression Compares the practice of CBT in Germany and the UK. The luxury of having 60 sessions in Germany vs

Emergent themes	Original transcript	Exploratory comments
The need for realistic expectations	then 30 group sessions, so again that is, you know, a lot. Amm, so **limitations are I think potentially accepting that some symptoms might stay longer, amm, and being realistic in what can be achieved in the therapy**.	short term work practice in the UK Need to be realistic in one's expectations
	R: How do you understand 'madness'?	Moving on to the next question on the interview schedule
View of 'Madness' as derogatory word	Well, I wouldn't, I mean I wouldn't call it madness, [*smiles*] amm, so I, do you mean how I understand why people are schizophrenic or?	Negative response to the word 'madness'. *Schizophrenia and madness are two different things, what is madness then? Is madness bad? Seems the word 'madness' has a derogatory meaning to the participant. Yet, he uses the word 'schizophrenic' which is also derogatory*
	R: Yeah, what's sort of your understanding, how do you make sense of it?	Clarification
The importance of finding meaning of hallucinations given client's history	Amm, I mean, I sometimes think when it comes to hearing voices for example I almost sometimes think when you look at the content it is a bit like, so I think you have to look at it individually, so what is the issue here and I think with someone, for example who is hearing voices and the voice is always very punishing or very, you know, for example I remember one patient who had, it was always a male voice, it was always rather critical and punishing and it was yeah. So, so then, I think you have to work, try to understand it with the patient right, how does this relates to you? this isn't coming, you know, this isn't completely different from you, it has some meaning, it has some relation to you, and in that case, it was, I mean, you	Individual approach to understanding schizophrenia. The importance of individual's life events. Talks about the content of hallucinations of a particular client. They make sense given the client's history and upbringing (sounds like he explored with the client the early experiences which lead to these punitive voices being internalised - seems like the participant practices

Emergent themes	Original transcript	Exploratory comments
Understanding schizophrenia as different from madness	don't have to be Freud, you know, it was linked to his, you know, it focused a lot about his relations to his father who had a very difficult relationship, who constantly, the sense that he didn't live up to his father's expectations. So then, you know, the therapy or part of therapy was about that, looking at that and also at how that changed now that he is ill. Amm, so I think you have to work, I think what I try to do is, I don't see it as something you know, something that has come over them and just sort of 'mad' in inverted comas, there is a meaning, there is a meaning and there is, related to them and it's about finding out what that is, ammm, that's how I make sense [*pause*]	CBT with a psychodynamic elements). I wonder how he understands the causes of schizophrenia though, he focus on the content of hallucinations, yet doesn't explain why not everyone with punitive parents experiences hallucinations. (The importance of meaning of hallucinations I wonder how the participant separates schizophrenia from madness. Oxford's dictionary's definition of madness seem to be very similarly to DSM diagnostic criteria, yet it seems to be unacceptable for the participant to call his client, whom he cares so much about, to call him mad. Is schizophrenia now a politically correct word for madness?) So madness is something that just comes over and is ultimately meaningless? Schizophrenia as a meaningful experience and the aim of therapy is to find such meaning
	R: How was it influenced by, say your training, your colleagues, the	

Emergent themes	Original transcript	Exploratory comments
	setting you're working? Your understanding, how do you think it was influenced by that?	
Training organisation communicating being cautious with clients with schizophrenia Acknowledging the fear of schizophrenia in the public Societal stigma Public perception of threat	Amm, with my training I think I had quite a thorough very broad training, so we, but as I said earlier **there was always a little bit of sense of this is all good for these client groups, you know, borderlines, or you know, CPDs or depression or anxiety but be a little bit careful** with, with, with schizophrenic patients, so there was always this sense of be careful. Amm, I feel that lots of people from my training were little bit scared of them in terms of, I don't even know what it was about, but I wonder again, whether that was you know very much influenced by society stigma amm, by the sense of 'are they mad'? you know what I mean, I am very aware for example when I read newspapers and I remember reading, I think it was 'Evening standard' or 'Tube' and if someone, I think incident was that someone got attacked or something and the article mentioned that he was schizophrenic and, and I am really, I am really aware of that often, you know, the, the diagnosis schizophrenic still gets mentioned. And I am not sure if it was mentioned if it was another diagnosis, so I wonder really whether there is awful lot, you know, of stigmatisation, people, you know feel that there is something threatening about them. And I do wonder sometimes how much it comes up in, in, in,	Psychosis and schizophrenia are perceived very differently in training institutions - a group of clients one has to be careful with. I get a sense that the institution was almost suggesting the untreatability of schizophrenia and subtly discouraging therapists to work with this client group. Participant's perception of people's fear of the severely mentally ill The role of society's stigma in inducing fear The media presenting mental illness as a reason for antisocial behaviour Participant's disappointment with unreasonable stigmatisation Public perception of threat
	R: Do you feel there is anything threatening?	As he just mentioned threat I wanted to explore how he felt about it
Absence of physical threat (apart from one off example)	No [*short pause*] not at all. There was one patient, he was, really in a project, he was really, really unwell and just went on and she didn't want to go to hospital and we talked about it for weeks and weeks	Unlike other participants, he did not feel physically threatened. So is he saying that the threat as

Emergent themes	Original transcript	Exploratory comments
	and she was better and she got worse again and there was one moment when she said, we talked with her and my colleague and she felt very, I think, threatened by us and aaam, you know, and we said, we made sure we can always stop and if it's too much, you know, you know, it's up to you if you consider going to hospital again and she was very, she was raging, she was not only schizophrenic, she was also PDs, she was also drug addict, so lots of different things as well and that was the only time I felt threatened in terms of, amm, thinking she might hit us or she might you know, she was really	perceived by the public is a myth? Mentions other difficulties the client had: drug addiction and personality disorder as a possible reason for her violent behaviour/presentation
	R: So physically threatened	
Therapists' fear of clients diagnosed with schizophrenia Confident & enthusiastic about the value of psychotherapy Support and influence of colleagues on one's work	Yeah, yeah, physical, yeah, that was the only time a part from that in, I am working as a therapist for 7 years and it was the only time. In terms of the influence, I just wanted to finish that, I think amm, so yes I think I sometimes wonder, you know, **even therapists can be a bit afraid or worried** amm, but I had one colleague who did a PhD also on schizophrenia with her I did the group, the group for the, ammm outpatients in hospital in Germany and she was very enthusiastic as well and we always we really wanted to do this group and we came up with this group and recruited patients, came up with a little program for the group so we really shared that amm, that interest. So with, by her, I felt very supported by her and I think we supported each other [*pause*]	Only one physically threatening client in 7 years of full-time work with schizophrenia Therapists' fear of clients diagnosed with schizophrenia The influence of a colleague who was particularly interested in schizophrenia Interest in group therapy Support of the colleague
	R: Where does this interest come from? About working with clients with psychosis or schizophrenia?	As he mentioned 'shared that interest' I wondered what was it particularly interesting for the participant
	Yeah, I sometimes wonder whether, I do think that as a therapist when you work for a while or maybe even, I think you quickly notice that maybe some patient groups you like more than others or	The interest came with time and experience. I wonder what was he getting out of working with this client

Emergent themes	Original transcript	Exploratory comments
Sense of a shared experience with the client as a motivation to work with his client group Importance of therapist's experiences and biography in attracting a therapist to this client group Clients' sensitivity is valuable for the participant	you like to work more with them. Amm, so I have a colleague and she loves working with borderline patients and I am a little bit like mmmmm, not so much, I mean I can do it and I do it but it's not a group of patients that makes me, makes me excited. Amm, so I think there is sometimes just a general after some years you build up an interest for, for one group maybe more than for another or you have more affinity to them, so you know, that one thing I think another thing is really aam, **I think based on my biography I can, this whole question of perception this whole question of aaammm, I mean I can see some links I mean I never you know never experienced it, thanks God, but, but I can I can relate to it a little bit in terms of you say some things and others perceive it differently so I do think there are some, I can relate to it a little bit, I do sometimes wonder whether therefore I can understand it to some extend just the sense of amm, yeah, feeling unsafe or feeling people don't understand around you**, because I do think that very much what they experience as well in a way. I think it's a bit like I would say this is green or white and you would say no it's black but no it's white and this sort of sense of, you know, so I do think and also again I think their sensitivity I can, I really, trying to think I think we all are sensitive but I pick up a certain sensitivity with them in particular that I'm really quite drawn to	group that he did not from other groups, for example borderline clients do not resonate with him that much. Feels affinity The influence of participant's own experiences of being misunderstood helps him identify with the clients and relate on a personal level to their difficulties Being unsafe and misunderstood feels familiar to the participant Refers to this point again (above)- sensitivity that he is drawn to
	R: I suppose we can all identify to some extend with those experiences, they are normal experiences but just, perhaps, a lot of that experience	
Understanding the symptoms of schizophrenia as ordinary experiences of	Yes, yes, exactly, exactly. There is more this sense of, you know it's a continuum and their experiences are, you know, just heightened you know, but I think that very much something that you have to put	The experiences which are common in schizophrenia (symptoms) are ordinary human experiences of higher

Emergent themes	Original transcript	Exploratory comments
higher intensity	across as a message to them that you know I mean I think we all felt paranoid, you know, not to their extend but some extend, yeah, or misunderstood, or [*R: inability to trust*] inability to trust, exactly or yeah, so I think, it's just a heightened as it always is I think with mental health issues it's not something completely different, you know, I mean with all these things I think it's just a heightened ammm version almost.	intensity. Participant normalises the symptoms of schizophrenia when working with clients.
	R: Is there anything in your biography that made you particularly drawn to this client group?	I wondered whether there was something in particular in his past that determined his interest of working with this client group
Fascination with mental hospital environment –	I really think it is amm, I mean if I think about my earliest, amm, contact with people who had schizophrenia was when I was 19 and I lived in for a year and I met this very interesting patient who was schizophrenic who had travelled a lot and he was an artist and amm, very reflective about the world and when he had a sort of moments of you know when he trusted you, quite sort of illusive you could have a really interesting conversation with him about life basically, so there was always something philosophical about him and I think that influenced it to some extend amm, does it answer the question? yeah? [*R: Mmm*], trying to think whether there were any other I mean, it doesn't run in my family, I never, you know, I didn't know anyone amm, who suffered from it until I was 19, 18-19. I did, when I was 18 and I suddenly had this idea to become a therapist amm, I, I went to a hospital and spent a summer basically working on a closed ward for a few weeks in my August holidays and I loved it. Amm, and I just decided I want to become a therapist, of course I think, I had very little understanding you know what is, what a therapist	Being fascinated by a patient - interesting well-travelled artist. Having interesting conversations with a client about life - reflective and philosophical. No schizophrenia diagnosis in the family. (I wonder though why did he become a psychotherapist? It is likely that there were family difficulties of some kind) Summer work in a mental hospital

Emergent themes	Original transcript	Exploratory comments
'parallel world' Kindness and responsiveness of people with schizophrenia as an attractive quality	actually does but it just felt to me like, something very interesting about it, I don't know, I can't explain it, there was something very interesting and different and also like a parallel world, also a little bit like amm, you know this ward it was closed and it was so, was sort of separate from the outside world and you, you, I mean obviously I wasn't a patient, but you as an outsider coming to that and you know you get to know the people and, and I really experienced that they all are very kind and you know, and very interested in getting some interest or receiving some interest so they were very happy to talk and you know and I found it, I had a really good experience there basically.	Fascination and passion (Also, after the interview the participant told me he felt very passionate about this topic and wanted to do something to make psychotherapy more accessible to people with schizophrenia) Kind people wanting attention. I wonder whether the participant felt important, wanted and needed there - is it this sense of being needed by the vulnerable who have little social interaction that motivates him to work with this client group?
	R: You say it's interesting and fascinating, tell me more about it? What is it that is interesting?	
Finding people with schizophrenia very interesting	I think it's just, just, what I find interesting was just hearing about their lives and hearing about amm, hearing about their struggles and hearing about ammm, I can't really explain it I think it's just sense of, as a teenager I was sort of I was 18-19 then you know and on this ward and later as well I just sort of felt **these are really interesting people**. Ammm, and in terms of you know their background, in terms of this disorder they have, this mental health problem they have and how they deal with it, how they struggle with it and also how amm, [*pause*] yeah, I can't explain it there is [*pause*]	*Participant struggles to define what is it exactly that fascinates him. An experience that is very hard to describe with words* Interesting people People's struggle through mental illness Difficulty to articulate his experience
	R: but something fascinates you	
Sense of connection and closeness as a motivational factor	Something really interesting I think just also, ammm, I think, I suppose **I feel this sense of connection a sense of closeness that I really enjoy, it's not like with, sometimes with other patients**	Talks about how he feels with his clients and is now able to find words to describe it.

Emergent themes	Original transcript	Exploratory comments
Clients' ability to establish trust as a rewarding aspect of work	**groups you have to work a lot through defences, I mean you have to work a lot through, you know, their coping styles, of, you know, let's say, borderline patients who can be very aggressive or can be very critical or and that's all part of the, the, the you know, the issue, but takes a lot of time to get there, you know to get there to what's behind it, if that makes sense, and to and I felt that with those patients who I met in hospital then and later in Israel and later in my work I often feel it was not necessary, that there was straight, you know, straight away a level of closeness or trust** or. Does that make sense to you? [*R: It is, yeah*] Ammmm, I don't know how much I make sense for somebody else [*R: absolutely*], but	Establishing emotional connection with clients with schizophrenia is easier and faster than with other client groups who use powerful defences to keep people away - relates back to the point made earlier about the vulnerability of clients with schizophrenia. "takes a lot of time to get to what's behind it" - almost as if he is talking about a mask (defences/shield serving to protect the client), and that clients with schizophrenia do not have that mask? This openness and genuineness that draws him to this work?
	R: If you were to give advice to therapists who work with this client group, what would that be?	
Importance of supervision with a practitioner experienced in the field of schizophrenia and psychosis Importance of learning about schizophrenia Importance of working with clients' difficulties	Amm [*pause*] my advice would really be obviously get, you know, amm, you know, **work with supervisor who is not afraid or has worked with patients who suffer with psychosis**, you know do some workshops on it or read about it ammm, but I think from a, less from, I think more from your attitude from your, your, you know, point of, of, of you know reacting or acting to them or working with them is really shame, I think shame is important to talk about to be aware of that and they might say 'no no no' but really be sensitive to that in terms of shame about their diagnosis, shame about what I said earlier being admitted suddenly or being seen now as ill you know,	The role of supervision Talks about what is helpful to do in therapy with clients - addressing the issue of shame

Emergent themes	Original transcript	Exploratory comments
such as shame Importance of empowering the client Importance of working with clients' difficulties such as loneliness	by their parents or by their social network. Being, yeah, so I think it's a lot about that, making them understand really, really important that they get some sense of understanding why this happened to them and therefore also becomes more controllable I think, more sense of 'I know where it is coming from, I know why this happened, I know more about it', then it also means that you empower them by, you know, giving them some tools but also then giving them the sense of 'ok I can do something about it, I have an understanding of it, it didn't just happen to me'. So I think really the sense of empowering them is very important. Amm, and it links to what I said earlier in terms of, you know, not just seeing them as ill and helping them to see themselves as not just ill, that they have, you know, resources, external resources, internal resources, strengths, abilities, you know, traits as a person, so I think those things are really important. And also being aware of loneliness, you know, they are quite lonely, because I notice for example in the project where people were quite chronically ill it was a huge issue just to interact with each other and just connect with another and of course that due to their symptoms and I think it's something I would watch out for as well, amm, giving them a lot of, maybe also how they come across ammm, to you, maybe not straight away but sort of once you feel they are, you know, they trust you or built a good therapeutic alliance amm, sensitively and empathically amm, giving them sense of how they come across to you or when you feel they seem a bit distracted and you suspect maybe they have acute symptoms in the session sort of offering it and matching it with their perception, I think that is important too	Exploring with the clients the nature and the causes of schizophrenia, helping them make sense of their symptoms and experiences Empowerment Seeing beyond the diagnosis Being aware of the strengths and resources the clients have Importance of being aware of the loneliness clients often experience Mirroring
	R: You said that, well your observation is the quite a few therapists	I went back to the point he made

Emergent themes	Original transcript	Exploratory comments
	are afraid of working in this field [yeah, yeah] *have you ever felt afraid?*	earlier hoping to explore the nature of fear
Absence of fear	No, I mean the only time I felt with this patient, at this project with this patient who was so agitated amm [*that's when you felt physically threatened*] physically, threatened yeah, and then stopped it but **I never felt afraid, because I think they are so much more likely to do something to themselves rather than to, to, to us than do to others**	Vulnerability of the clients and the risk of self-harm/suicide
	R: What about different type of fear, not that they would do something to you but. The reason why I am asking this, I haven't worked much in this field but I had a few clients, and there was one moment when this client she, she saw dead people and when said that there was somebody standing behind me I remember having this feeling that I want to turn around and make sure and I kind of thought, 'am I losing my mind?' So, for me this is the kind of fear, different sort of reality and I wanted to test am I still perceiving it correctly.	This is a very leading question. I wanted to ask whether he experienced the fear of losing one's sanity as it was mentioned by other participants. However, this question was not appropriate for an IPA study as it was very leading.
Grounded in his perceptions and sense of self Empathy	Yeah, I can, I can, I think I know what you mean, amm, I don't, I never had that, I never had that, I sometimes, if I listen to how they perceived, you know, if they are talking about hallucinations or how they perceived, threatened by, you know, the environment, they felt threatened by the environment because of their hallucinations, delusions, I sometimes sort of I just imagine what that must be like and thinking oh that must be terrible or that must be really, you know you, feel their anxiety and that is something that I feel but I, I remember one patient describe very, very graphic amm, blood coming down the walls and him being raped by amm, by, by animals and really graphic things and black eyes everywhere that watch him	Unlike other participants he did not experience a state of altered perception 'feel their anxiety' – sounds like he describes empathy. However, this is not specific to this client group

Emergent themes	Original transcript	Exploratory comments
	but I never felt threatened in terms of my own perception or that amm, you know, that I think maybe I go mad now or you know, I lose my mind, sense of self and my potential or I question my perception, not in that moment, no	Grounded in his perceptions and sense of self No questioning of perceptions
	R: Was there any client that stood out for you?	There were no more questions on the interview schedule but there was still some time left; I hoped that with this question he would remember some particular experiences that stood out
Realistic view of the progress in psychotherapy Empathy	Ammmm, I couldn't choose, I mean I just, [*laughs*] I am just going through my head, him or him or her and then I thought actually find it really difficult to choose any of them because I mean there was one client that I found very interesting who. I am not so sure it was a successful therapy I mean I don't want to portray a picture now that it's, picture that it's always, you know, feeling great, it always works, sometimes it doesn't, but, he told me about what happened for him when he was very psychotic and he, he was an artist, again, I quite I am interested I think, and he, basically there was this voice that said to him that he has to keep working and he has to keep working so he was described he was in this under church in this studio on his own in this dark studio just with this little, with little window and he just he, he, he stopped drinking and stopped eating and just worked and worked. And because, you know, that's what he heard he should do and when he went out to eat something eventually the voice said he should, he went to a Vietnamese restaurant and the voice said that he should eat every rice corn, aaah, every single rise corn basically, he sat at this restaurant for hours and hours and ate every single rise corn, I mean that is something that	Incidents of unsuccessful psychotherapy with psychosis Recalls a story of one client Compassion and empathy

Emergent themes	Original transcript	Exploratory comments
Sense of closeness as the main characteristic of the experience	really stayed with me for example as something terrible, must be very frightening, must be terrible. But when I, **when I think about them what stays with me is really a sense of closeness. I can't describe it in any other way**. Mmmm [pause]	Sense of emotional closeness
	R: Is it emotional connectedness?	Checking whether I understood him correctly
	Yes, yeah.	
	R: Would you recommend other therapist to work in this field?	
Promoting work with clients diagnosed with schizophrenia	Whether I recommend people choose, to work, to work with patients with psychosis? Oh for sure, for sure. I really think	Promoting work with clients diagnosed with schizophrenia
	R: Coz, like you said, majority of therapists would probably avoid working with schizophrenia	
Stigma among psychotherapists	I am not sure if it's the majority and again I don't know how much that it changing, I think that is changing and I don't know how much that is, amm, maybe more issue in Germany than is here, I don't know because I haven't trained here, but I do feel, I do wonder whether there is a stigma in society and it also slightly exists in sometimes I think in, in therapy settings. But I would definitely recommend it, amm	(Important to note: the participant did not train in the UK) Stigma among psychotherapists, an excluded client group
	R: What do you think are the benefits for the practitioner?	
Sense of neglect of this client group in psychotherapy	**Well, I think, I think, as a, as a profession, I think we need to make sure that we are not neglecting any, any groups of patients and we don't just think as psychotherapists or therapists that or we can't work with them, and all they need is medication, I think medication is part of it, yes, or can be but I don't think we should just leave them** to that amm, so I think we have a responsibility in a way amm, was it, was it? answer the question?	He does not answer my question Responsibility to treat any client group and not to exclude clients with psychosis

Emergent themes	Original transcript	Exploratory comments
	R: Is there a difference for you in terms of how you feel, experience working in outpatient setting or inpatient?	Because this participant had both experiences I wanted to explore his experience in those difference settings. Tried to focus his attention on his experience.
	Yeah, quite a bit. But I wonder whether the difference is actually just time, because with inpatient setting the way it works here is that the group never settles, there is a lot of group work here and that means you have constantly different patients and you might see them you know, I might do group on a Monday, on a Wednesday but not on a Tuesday, that means you don't see, I don't see patients, the same patients group every day or you know regularly, so I find that tricky. Whereas with outpatients at least you have the, the continuity and the I see you every week and I see you maybe for 20 sessions or you know in Germany as I said you know 60 sessions. So I think that makes a difference. Amm, also the work is a bit different with the outpatient you know, there is probably higher level of functioning so that means that what you focus on might be different with them, might be more about you know the work on the symptoms and behavioural activation and making sure they are engaging in activities and have social network. Whether inpatients it might be working on acceptance that they are here and they are suddenly in hospital or building of trust. And then you can do a bit of psycho-education. So it changes a little bit I think in terms of what you work on with them, but also I think for me it changes the amm, amm, there is less continuity, there is less time, there is less chance to build up a relationship if that makes sense.	Refers to his work in a private hospital in London Difficulties of the open group: lack of continuity and shift in the focus Lack of continuity and inability to build a relationship in open groups of inpatients
	R: What do you enjoy more group work or one-to-one?	

Emergent themes	Original transcript	Exploratory comments
Importance of building a relationship Establishing an emotional connection	I enjoy more on-to-ones amm, having said that though, I think close group can be very, very powerful, I've done that in Berlin because you really, it becomes a real strength for them and they, it becomes a group in which they feel very safe and amm, and you, as a therapist as well, you know, because **you settle and you build the relationship and that's something I really, really enjoy**. Ammm, I find groups more difficult because you have to focus on different people and sometimes I think you have to be a bit more directive for example, and then you know, you want to give them all something but they might not get it and then you feel, so I find it more difficult and also just having a group in front of you and you have to, you know, work with them and you have to understand them very quickly so you have to be quite quick especially in the inpatient setting. But then it can be very, I can, I can really enjoy it sometimes, if you feel people connected, people opened up in a group or people got something out of the group or got something from you. Amm, so group can be quite powerful if it works, I am not sure in one-to-one setting I think it is more powerful in the long run, if that makes sense. So I think I prefer groups, I prefer one-to-ones over groups but I think groups I can enjoy them as well. I mean.	The value of group psychotherapy in terms of empowering to the clients Feeling safe and settled - important aspects of work for a psychotherapist (not schizophrenia specific though) Challenges of working with a group Importance of 'connecting' - participant keeps referring to importance and enjoying this aspect of work with clients with schizophrenia - establishing an emotional connection
	R: Well, we went through all of the questions I've prepared, it there anything you thought I might ask and I didn't?	
	Amm, is there anything you didn't ask but I think is important? [*R: mmm*] [*pause*] No, I don't think so, I mean I mean, do you feel we covered, do you feel you've got what you needed, yeah? I think so, yeah amm. I don't, I don't, I hope it came across, what was important to me, but no I don't	
	R: Ok, shall we stop it?	

Emergent themes	Original transcript	Exploratory comments
	Yeah.	

PARTICIPANT 5 – EMMA
Interpretative Phenomenological Analysis of the interview transcript

R: Text – stands for researcher's interventions
Bold – Notable quotes, used in the results section for illustration of the themes
Exploratory comments: Descriptive comments (normal text), Linguistic comments (*italic*), Conceptual comments (underlined)
Square brackets and italic within the transcript – descriptions of non-verbal communication and background sounds

Emergent themes	Original transcript	Exploratory comments
	R: So, tell me about your experience	
Negative view of the medical model Participant's own experience of being diagnosed with depression Need to bracket off one's view on diagnosis View of the diagnosis as negative and unhelpful Normalising client's	Ok, so, my experience working with someone who had a diagnosis of schizophrenia was while I was on placement as training psychotherapist at Greenwich Mind and was probably my third client so I was relatively new in terms of placement and I remember that I was clear about what my beliefs were about the medical approach to schizophrenia having obviously been through my own experience of depression earlier on in my life, not being really satisfied with what the medical option which was really tranquilize you with either antidepressants or other kind of drugs and so when I was referred this client all I got was said that diagnosis of schizophrenia and **I had to bracket my own feelings about what I felt about someone with a diagnosis or a medial model approach so I was really keen to not get caught up in her diagnosis and allow her to come in as who she was** and what she brought to therapy so, that was my awareness of myself before I met her and so when I did meet her finally, you know, **she appeared like every other person would appear very articulate, aware, intelligent** and some of the things that she first	Context: Voluntary organization Time in career: inexperienced Negative view of the medical model founded on personal unsatisfactory experience of liaising with medical staff Medical option: tranquillisation, numbing the feelings Need to bracket off feelings, I wonder what she felt, was it something negative, judgmental? Is it an attempt on humanistic illusion that you can forget what you know whenever you want to? View of the diagnosis as negative and unhelpful. Viewing diagnosis and the person as

Emergent themes	Original transcript	Exploratory comments
experience of schizophrenia Participant's need to normalise the experience of schizophrenia as a way of rescuing a client Staying with client's experience as challenging Desire to rescue a client	presented were the fact that she was not satisfied with this diagnosis having said this she'd been diagnosed since she was in around her 20s and she's been sectioned about 9 times so there was a bit of disparity between the fact that she refused to be diagnosed as schizophrenic and the fact that she'd been sectioned 9 times but because how I felt about medical model I was keen to just support her in acknowledging that, that wasn't schizophrenia so in our initial sessions we worked primarily with normalising her experience and what I mean by normalising her experience was that you know when I asked her what she saw as successful, for her it was just to live, quote, a normal life which meant having a job, a decent boyfriend and the [*inaudible*] events and as a result of that she was enrolled in a secretarial course she used to go to every week. However, what I noticed was that when she would go to the course her paranoia would be quite heightened and the paranoia was centred around how others saw her, perhaps something wrong with her which ignited her internal struggle even further with the diagnosis. And for me the challenge here was trying to stay with the experience and not pathologising it but the paranoia, the aspects of, excuse me, what defines schizophrenia as you look at DSM 4 or 5 whatever one is now, paranoia, so we worked essentially in trying to support her in normalising that experience if you like and towards, I would say she went to about 4 sessions of this course but towards the end she kind of sabotaged it and didn't show up and was convinced that the experience would end up being negative for her and again **I had to bracket myself in terms of trying to rescue her**, wanting the best outcome for her to support that actually regardless of what diagnosis she's been given you know this is an opportunity for her to get her life in order and pretty much I saw her for about 12-13	separate, is it impossible to experience both the person and the diagnosis? Normalisation the clients looks and is experienced by the participant like any other client Is there a similar disparity in the therapist, despite the diagnosis and 9 sections the therapist tried not to see what was 'wrong' with the client and just focus on the positive reinforcement? Need to normalise. Whose need? Therapist's? Is it triggered by desire to rescue the client hoping that a client can just get on with her life despite the difficulties? Shows therapist's inexperience at the beginning of her work with this client (desire to act out the uncomfortable feelings)? The challenge to stay with the experience. Need to rationalise, explain and not to pathologise the experience?

Emergent themes	Original transcript	Exploratory comments
Difficulty to stay with the experience of the client	sessions and pretty much in the middle or the sessions she started talking about her partner at the time and what I found quite interesting was that she had met him in an institution after being sectioned on one of the occasions and he also had a diagnosis of not schizophrenia but bipolar and I found that quite fascinating that you had two people here that having challenges with their mental health and they come together but what I found was they, particularly the client, would feed of each other's challenges if you like and there was a huge power struggle in the relationship and during the time, during therapy he had been sectioned for another, he was in hospital for another incident that happened and this is when it became quite interesting for me to observe the power struggle because he would call and [*R: she would refuse to visit him*] and she would refuse, she would say 'yes' but she would refuse to and she kind of delighted in the fact that she had this control, power and as result but the time, I think the hospital stay was short, by the time he had left he must have established a relationship with someone else and started being punitive towards her when he came out by not returning her calls because now he was out she wanted him to be back together with him and this is all. When they were together she wanted him because she, she felt being alone was too difficult for her but when he was there she found him a hindrance to her environment, he would use up most of the bed, she said he would smoke pot all the time but for her having something is better than nothing and I think, I experienced her as being quite resentful of that even though she went ahead with it	Participant is describing the client's story and the content of the sessions that she found interesting. Her interest in the power struggle I am recalling this material as I read her MSc which was a case strudy of this client.
	R: What was is like for you to observe that power dynamic?	I am trying to bring the participant away from client content and back to

Emergent themes	Original transcript	Exploratory comments
		her experience
Experiencing her client as different from a common stereotypical view of a person with schizophrenia – normalising the experience of schizophrenia	Well, for me, it was really just more of a recognition that despite having this diagnosis as I said at the beginning, her intelligence levels and her ability to articulate things were high and so perhaps, you know, the generalisations of people with this particular disorder is that their cognitive skills are perhaps aren't as sharp as someone who doesn't have sch... diagnosis but hers was quite the opposite, it was really sharp. So yeah, I think for me it was about being aware of that, being aware of how passive aggressive she would be and for me I just wanted to observe and watch the process happen. So as a result of all of this as the weeks went by she became more and more volatile towards him because he wasn't showing up for her in a way she wanted him and apparently started another relationship with someone else like I said earlier on according to her and she would come into therapy and the focus would be about the possibility of this other relationship and there was part of me that I had to make her accountable for her role in where the relationship was and as a result she interpreted this as me siding with the boyfriend and that somehow I was colluding with this process and that I had more knowledge than she had and this was the time when **I started to experience her in a very different way so up until that point I was, I held the fast line kind of existential beliefs and wanting to stay with the phenomena of what was going on in the room but then I started to observe something very different about the person that was sitting right in front of me and I was, it was early in my career, and first I was a bit amm I guess I felt I didn't know what to do observing this situation other than taking it to supervision and in our last two**	Challenges the generalisations and stereotypes about people with schizophrenia, break the stereotype of 'crazy-stupid-inarticulate'. She points out client's responsibility for the situation Feeling misunderstood by the client Changes in the relationship as the client was close to a psychotic episode Need to hold on to theory for support Not knowing what to do, lost. Participant explains feeling lost as lack of experience
Psychotic episode as dramatically shifting participant's experience of the client and the relationship between them		

Emergent themes	Original transcript	Exploratory comments
Client's anger projected onto therapist Misunderstanding (Client and therapist as two different realities) Importance of experience on the ability to tolerate the feeling of being lost 'Taking client home' Questioning one's views	**session the person that sat in front of me was quite different from the person was sitting in front of me in session two**. Amm, eye, eye contact became non-existent, she wasn't able to [*inaudible*] almost as if her eyes were glazed over but I always wondered also whether there was effect of the medication that she was on that made her that way and then she projected all of her anger, whatever anger she felt towards her boyfriend came transferred across to me in terms of her believes that I was colluding with him and she stayed for 30 minutes in final session and she said she can't stand it and got up and said was going to leave. And as I said it was completely different person walked out, slammed the door and I kind of sat there, damp [] just questioned my own views about my approach about going into the sessions which was actually there isn't necessarily a medical answer to why people become psychotic or schizophrenic but I was very aware of the fact that she was different from the initial session and that actually it was the beginning of her going into psychosis and then within the next three days she was sectioned as she had a psychotic episode and I wrote to her in her hospital but I never got a reply because I did want to follow it up. And so I did a lot of reflection after and over time I reflected more and more and more and reflected on her narrative and I think what brought her to that point in her, in her life or her initial psychotic episode and the continuation of it. And so for me there was something about her wanting to normalise her life but on the other hand when she was in situation where she was normalising her life I think the, the needs that she desperately needed that weren't met by her primary caretaker as a child would become overwhelming and the only way that she was able to get those needs met was to be, was to go into psychosis and she told me, you know, in	Need for supervision to help with the feeling of being lost <u>Critical of the medication. Medication as disconnecting the client</u> Medication was getting in the way of establishing emotional contact <u>Rupture in the working alliance</u> <u>The impact on the therapist of clients projected anger and transference is alienation.</u> Unexpected ending for the participant I wonder what was she thinking when she sat there, feelings of failing the client? reviewing work? questioning one's naivety? She knew there was something different just before the client had a psychotic episode: paranoid thinking, powerful projections – loss of ego strength, fear, chaos and blaming A lot of time spent thinking about the client to sort out all those projections and unresolved feelings left with the

Emergent themes	Original transcript	Exploratory comments
Role of theory in helping the participant to tolerate the experience by trying to make sense of it	a session that when she was sectioned that those needs were met, the care that she so desperately needed. She was sectioned. And so, for me, I guess I still hold true to my beliefs that what happens in the, in the initial stages of a child's life can have detrimental effect on their experience going forward. The medical opinion says that it is something genetic, I don't know point to a single gene that confirms there is, so for me I think it's still open, there is still an open discussion and it's important to look at	participant after client's unexpected leaving Participant is trying to make sense of her client's difficulties in terms of attachment theory Firmly grounded in the theory Sceptical about the bio-genetic model
	R: So how do you make sense of this? Why somebody would develop schizophrenia or psychosis?	
Psychosocial understanding of the causes of schizophrenia Protective role of theory	I don't, well, my belief in making sense of it is that there is something, **I believe that if there is huge disturbance in the initial stages of child's development in relation to their attachment figure, I think that can lead to a situation where a child will develop a sense of finding the world unbearable** so if I think about this client she was born to an affluent family and pretty much left to her own devices from a very, very young age, like 2 or 3, lived in this really huge house, father was almost absent, he was a television producer, mother was an artist, a narcissistic mother too, she was more interested in her own life and essentially left this child to wander around on her own, with herself. You know if we think about some of the, some of the fundamental aspects of the attachment theory, one of the fundamental ones is the relationship between the child and primary caretaker if that's developed with a secure attachment it gives the child tools to find and navigate their way through life to develop a	Makes sense of schizophrenia in terms of Attachment theory Thinks of the theory as applied to this client Describes insecure attachment and isolation is causes

Emergent themes	Original transcript	Exploratory comments
	sense of self but to leave a child in isolation, I find, I believe children would find that difficult to develop a sense of self and therefore will create their own world. So if we also think about child's need for safety in the initial stages of life, all they have to rely on their 5 senses and it's really up to the primary caretaker to help them develop their senses to where a child feels a sense of security within themselves to go out and navigate their relationships not only with themselves but also with the external world so if that's disturbed I don't find it surprising that a child would withdraw into their own world where they would create their own sense of safety and withdraw from the external world which does feel unbearable and aggressive towards the child so that's what I truly believe happened to this client and she talks about, you know, in our session she talked about developing her own world and the absence of her parents and she remembers vividly going into the garden or creating a camp ground visually and disappearing into that camp ground and that just developed over years to the point where she could actually go through this visible door in her mind and then come out in a way in an image that she saw would make her feel or look more beautiful, acceptable and loved more than anything so it was creating a world where again she would get her needs met and that's why I think it was so linked to her attachments earlier on in life I think after a while, after a while I do believe that someone who experiences psychosis, schizophrenia at an early point in her life [*the interview was temporarily interrupted by someone coming into the room*]. Where was I?	Explains psychotic withdrawal in Attachment theory terms. The theoretical 'making sense' helps the practitioner to normalise her work with the client, makes the client in her eyes understandable and thus removes the need to defend against the fear of the unknown, to impulsively rescue or pathologise. Theory protects and grounds the therapist. Makes the unknown, bizarre, alien phenomena more tolerable.
	R: What did you notice about your reactions, especially in those final two sessions when she changed?	Bringing her back to focusing on her experience rather than the client's

Emergent themes	Original transcript	Exploratory comments
		story
Experiencing anxiety Colluding with the client in normalising the experience of schizophrenia Inability to communicate with a shut off part of the client	I think **there was a lot of anxiety in my reaction** because up until that point, I held, I still my beliefs that, that actually there was a way out of this and my altruism and I think probably my naiveté as a therapist was just wanting her to be ok and so although initially I was trying to bracket my thought process, on reflection I was colluding with her in terms of trying to make the point that she wasn't mad and that she was normal and so for me yeah, I was anxious in those couple of sessions because there was I hadn't experienced anything like this before and I was unable to communicate with that part of her, it was very shut off and so the best I could do was just to let her know that I was there to support her	She reflects on her desire to normalise and with a hindsight sees it as colluding with the client. I wonder whether this inability to see the collusion at the time was partially the lack of experience (3rd client) and partially the demand from the client to 'make everything ok', and the fear of the unknown experienced by both the therapist and the client *Introduces terms 'mad' versus 'normal'*
	R: So you said she stopped looking at you, what was it like for you, so you said you felt anxious, what else?	Prompt her for more detail
Inexplicable difference in the relationship in the lead up to psychotic episode Experiencing anxiety	**I think really an awareness that something really different was going on in the room and the difference was really the person, and what was it like for me, I don't know, a part from the anxiety about what was going on I don't think there was much else going on for me**. It was two sessions and one of them was only 30 minutes long and I would say that the second to last session was really me trying to draw her in from her going off which I don't think in the end helped her because it made her more angry towards me and then ultimately I became, I was seen as the same the boyfriend	Feeling the difference in the person's presentation: before the psychotic episode and at the start of it. *She says 'something really different' but what is it? I wonder if she can't find the words to describe this experience,* is it an inexplicable experience? (Participant's story was based on her experience of working with one

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		particular client which made her account rather narrow. She didn't talk in terms of tendencies as her experience was limited to one case, thus making it impossible for her to generalise from it. This is in fact a limitation of this study. Away to improve the study design which would have elicited more rich data could be by restricting the participant criteria to 'practitioners with significant experience in the field of psychosis' only, for example 10 years+)
	R: She accused you as well, didn't she? [She did of perhaps I was sleeping with him too] *R: you became part of her paranoia*	
Schizophrenia is an alien experience Limitations and disapproval of the medical approach Influence of R.D.Laing	I became part of her paranoia and that was for the first time I thought you know maybe there is some truth here something different going on for someone who has been given this diagnosis and is it. Perhaps my view on the medical model was premature but I wanted to research it even further and over time I did and what I found through my own research made me feel that yeah there is a shift that happens for someone experiencing schizophrenia but I think it's an explainable shift and the triggers are all related to I think the earlier experiences of the child it made more sense to me. I read a lot of work by R.D.Laing who actually proposes that there is a benefit in letting someone go	Difficulty in accepting the medical model, yet unable to make sense of the experience and perhaps needing to relay on the medical model for explanation / during the time the client was entering a psychotic episode she seemed to begin to question her sense making and perhaps wanted some certainty thus referred back to the medical model

Emergent themes	Original transcript	Exploratory comments
	through the process of being psychotic and that they do come out on the other end rather than medicating them with drugs, with drugs that are quite lethal but actually dulls the client from their own senses and as I sit here today I still hold that belief	which attempts to provide a definitive explanation. In a state of stress there is a need for comprehensible reassuring explanation, perhaps, to resolve the highly uncomfortable chaos in the therapist which is stirred up by clients' loss of sense of reality. Yet, once distant from the client (on reflection) the state of control and reality within the therapist was regained and she resorted back to her original sense making that allowed her to connect with the client in the first place.
	R: If you were to give advice to somebody who works with that kind of paranoia, what would that be?	Moving on to the next question on my interview schedule
Staying with the phenomena as a way of working Need to bracket off one's feelings Rescuing as an attempt to deal with the anxiety	I think you've got to stay with the phenomena of what the client is bringing into the room, you've got to bracket your own feelings as best as possible and allow the process to happen really. I only had, I mean, the one experience, the eventful experience with this client and I haven't had multiple experiences of this level with different clients so I don't know, I can only go by how I approached it and how would I approached it today? I think I would be more confident in terms of allowing the process even the process by going into psychosis being confident to allow that to be part of the therapy rather than trying to rescue or make her accountable for her paranoia based on her actions,	Need to stay with the experience of the client Need to bracket off your feelings. I wonder whether she implies that it is difficult to bracket them off due to the immense volume of projection, therapist's anxiety and need to explain as a way of managing such anxiety. Need to accept the state of not knowing, helplessness and anxiety

Emergent themes	Original transcript	Exploratory comments
	so yeah, that's what I, my	without resorting to rescuing. Lack of experience – wanting to fix and 'make her feel good about the situation and herself
	R: Would you work with someone with schizophrenia or psychosis?	
Sadness for people diagnosed with schizophrenia	I do, I would. I think there is, f**or me I feel a lot of sadness for people with those diagnoses I feel that somehow through whatever experiences they have had that, perhaps, their opportunities to develop their sense of self, perhaps, may have not be as strong as those of us who don't experience it**, so yeah I would work	Empathy towards people diagnosed with schizophrenia, sadness is strengthened by this sense of injustice – 'it's not their fault that they are having those difficulties'
	R: And you don't just because clients don't come along or?	
Criticism of the medical model Feeling protective towards severely mentally ill Disappointment with current mental health system and lack of	Generally schizophrenic clients are not referred, well, in my private practice they don't come along. **I think part of the problem with people with diagnosis with schizophrenia that they become part of the system and the only way that the medical approach is to treat them is to treat them through medication. I don't believe that the medical approach believes in therapeutic approach** and therefore I don't believe these clients most clients being a diagnosis, I think, and there is a lot of factisisms that go into that if I think about the environment, National Health Service and the resources available to treat it I think all have an impact on a client's wellbeing. If the resources aren't there and in mental health in particular the resources have diminished with the cuts that have been going on recently. If you don't have [*inaudible*] to give the patient to give a good care pathway then it's not surprising that the only thing that they can rely on is	*'schizophrenic' – despite her annoyance with the medical model uses this non-PC word* [yet, therapy, particularly group therapy and CBT may be part of treatment and a number of patients have access to it] Limitations of the NHS Sounds angry that, due to lack of funding and dismissal of therapeutic

Emergent themes	Original transcript	Exploratory comments
resources	medication to give them some sense of stability and I also believe that it takes away an element of meaning in their life because their meaning becomes their diagnosis which stops them from participating in the external world even more and further isolates them and that further isolation exacerbates the diagnosis. So in an ideal situation perhaps some of R. D. Laing's work if the resources and the finances were there may have **greater benefit for people with psychiatric diagnosis to be in an environment they feel supported and allowed to be feeling without kind of being medically numbed through the toxic drugs that they've given to stabilise them**	approach, people with schizophrenia do not receive adequate support
	R: You said you feel sad or [I do] *so is this sadness because of the deprivation, lack of support they receive?*	
Sadness as a response to hopelessness about current options for people with schizophrenia Anger towards the imperfect/limited structure/ medical model Compassion Hopelessness about the future of people diagnosed with schziophrenia	**I think the sadness comes of sense of real hopelessness for them given the environment** that you know I also believe personally that what gives meaning to our lives are our projects and when I mean projects I mean our life, the project that are our lives that thinking existentially again, I think it was Sartre that pointed out that we always have a choice at recreating our process our own projects and I think that is a huge part of staying away from it when you are given this diagnosis because all you then become is a schizophrenic person who is medicated and if that's your meaning it often feels unbearable and perhaps can belling to rates of suicide within the patients diagnosed with schizophrenia, it's kind of almost hopeless	Sense of hopelessness for lack of support. Is she angry that people don't care enough for those who are mentally ill, reduce them to a number? Yet, she chose not to work in severe mental health setting such as hospital, I wonder whether is it partially because she is acutely aware of the deprivation, lack of funding etc but also absence of cure which leads to this powerful sense of hopelessness. It's too hard to fight the system, and this unbearable hopelessness might be keeping her

Emergent themes	Original transcript	Exploratory comments
		away from this field of work.
	R: And they can't afford personal therapy as most of them don't work and are on benefits [R: right], private therapy I mean	
Sadness about most people's inability to access help	So, that's the part that makes me sad about it. But it is what it is.	She can't and doesn't want to fight the system thus has to accept it?
	R: Have you considered working in a mental hospital?	Hoping this question would prompt her to think about negative aspects of working with schizophrenia as she obviously does not work in a mental hospital
	I have and actually **when I was studying I, I wanted to do at least a placement at mental hospital but the opportunities weren't available and a lot of mental hospitals, I don't know what they do today, but at that point they didn't offer placements to trainee therapists, it was more kind of clinical support and kind of mental health nurse practitioners** so being someone there to show up and give them their medication, help restrain them if they were getting out of control and I guess the psychiatrists were the people	Remembers her difficulties in finding a placement in a mental hospital at the time of her training
	R: I think it is still the same, I tried to get a placement and really struggled, I heard a few people did	
Lack of psychiatric placements during	Yeah, I mean it's more of an observational placement, I don't know, if you are allowed to do any psychi, psychotherapeutic work. So, but	Regrets not having had that experience but stresses how difficult

Emergent themes	Original transcript	Exploratory comments
psychotherapy training	yes, I would love to have done it even from an observational point of view but at the time when I was studying I was in full time work so between two clinical placements, full-time job, my personal therapy plus my academic studies I didn't really have much more time to do anything else	the training was at the time
	R: intense	
	It was, it certainly was for 4 years, but it was, but I am really glad I was able to do it all and get my clinical hours in 4 years	
	R: Where does your understanding of schizophrenia and psychosis come from? What, obviously you studied later on, but when you were younger? Did you see maybe people who were disturbed on the streets or anything?	Moving on to the next question on the schedule. I asked about her earlier experiences because she has already mentioned her current understanding and writers that influenced her understanding
	I may have seen, yes, I did see people that were on the streets, I mean I grew up in London and then moved to California but in central London yes, you used to see people that I probably then defined as alcoholics but that was through kind of lack of understanding. And now quite often when I walk, I mean in town you see a lot of people sitting on a side and they are drinking, my thought they probably have a mental health problem going on in addition to, perhaps, alcoholism is the only way they can cope	Early understanding of mental illness was by seeing it as alcoholism, which implies that she thought those people had made a conscious choice to be alcoholics (common children's view) With the knowledge of psychotherapy she reversed her understanding of mental illness; alcoholism is now seen as a coping mechanism
	R: Media likes picking at examples of especially schizophrenic person	This question is leading, I should have

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	and if it's linked to murder then it's on the front page, I don't know perhaps to elicit fear in people, have you felt frightened?	focused on exploring participant's experience. I should have asked 'how do you react to such headlines?' instead of suggesting fear
Inaccurate diagnosis as stigmatising /limitations of the diagnosis when schizophrenia gets mixed up with antisocial behaviour	No, I haven't been afraid and I think people, what I do believe personally, that people who do murder and perhaps being given that diagnosis are, probably should have an additional diagnosis because someone that has the tendency to murder probably doesn't have a solid developmental empathic skills at least for the client I worked with those skills were there, those emotional skills were there. So, I don't know whether the diagnosis is necessarily the right one. But I worked in the media too so I understand that their role, their only role is to get the headline and so whatever they can put through in the headline to make it sound more attractive and get the reader to read it they will do it.	No fear. I wonder that this is because her experience of working with schizophrenia was limited to this one client who was not aggressive. Questions the accuracy of the diagnosis which she believes is too broad and combines various fundamental deficits: lack of empathic skills vs thought disorder? Is sceptical about the media
	R: I assume you had difficult clients later on in your career; when you compare those difficult situations when a client was angry with you or walked out of the session with that example with that particular client that you brought, were there differences? As in, the actual diagnosis, did it make your work different, the way you felt different?	I encourage her to compare different scenarios to prompt her explore and see the reactions that might have being specific to this particular client
The impact of the diagnosis on practitioner's expectations	I think if I am honest given the paper telling me that this client was schizophrenic when I first met her probably did have an impact on my approach to who was going to be in the room, to someone who came to see me privately that tends to be more functional and not being sedated by drugs. However, I have been in situations where my, I	Assumptions that come with the diagnosis had an impact on the participant. There is something about the diagnosis of schizophrenia that made the participant to mentally

Emergent themes	Original transcript	Exploratory comments
	have worked with someone who has been very angry with me, it doesn't happen often but occasionally it does and it did in this particular incident with someone who has been suffering with long term depression for most of her life and the struggle with the work was always that the client almost saw the depression as something external and not part of him and again I found myself initially in the sessions trying to come up with or look how this depression developed so, you know, looking at his family history, looking at relationships, seeing if there's been any major triggers that gone on in his life to affect him to have a depressive episode at such a young age. But whatever way I tried to find out he would neutralise that by saying 'oh, no, perfect relationship with the family, loving relationship with the primary caretakers, school's fantastic' which was incongruent with what he was presenting and this is where I think my approach using Gestalt therapy perhaps, I find more useful because sometimes you have to say what's not being said in the room so in this instance I had, well I chose to make the intervention to tell him that there was an incongruence here and that people don't just show up depressed in the world and there must have been some experience or experiences that brought him to this point and again as with my client who was diagnosed with schizophrenia and with this client who had long-term depression, I think quite often what happens is that if the depression or the schizophrenia isn't caught in its early stages and a care pathway develops from the get go which can send them in two directions: the medical model so, taking drugs, or more therapeutic approach, which is looking at the, looking at their life and their experiences. That then can become their way of being in the world, so they become the depression or the psychotic patient because	<u>prepare, to lower her expectations – less functional and sedated by drugs.</u> Brings an example of an angry client Explains clients' difficulties in being aware of their issues by suggesting two options to the treatment plan – medical vs therapeutic

Emergent themes	Original transcript	Exploratory comments
Risk of going mad as a normal phenomena Family dynamics as a cause of vulnerability to madness	it just feels like there is nothing else. And although this client as I said was functioning and did have the choice to intervene with his own care pathway, 'well actually I am 19-20 years old and I am very depressed, I need to get some help here'. Quite often people don't do that, they only start doing that when it becomes unbearable and with client that I've worked with that had been severely depressed I think it's quite interesting the fine line between what's deemed sanity and madness. People who had experienced being severely depressed quite often had talked about wondering if they are going mad and again I think it's just a fine line. Perhaps we are always dancing on that fine line but the tendency to go to what's deemed madness is always there for everyone. Sometimes the triggers, they are easier for some people to cross that line than others and then when I did my research for my own dissertation about a journey through madness again the client was a co-researcher that I worked with, everything that pointed to her journey into madness was in relation to [*R: that is the book you are talking about?*] yeah, yeah was all related with her relationship with her mother. So I think there is something to say about sanity, madness and the family as written by R.D. Laing. It's all fascinating stuff!	That client had a choice and picked the therapeutic route. I wonder whether she assumes that people with schizophrenia usually don't and are simply pushed into the medical option. Client's fear of going mad when experiencing deep depressive episodes. Is it the fear of losing control over one's feelings and emotions which is associated with madness? Madness can be a potential reality for everyone. Normalising madness? Reflects on the origins of madness and links it to the family as stated by R.D. Laing
	R: Do you have any colleagues who are interested in psychosis?	
Private practice as a hurdle in the work with schizophrenia	I think at this stage in my career most of my colleagues are in private practice and had become removed from that kind of environment like I had really because the paying client is more functional and I think access to this client had become from being in an environment where they have access to it so from working in charities, mental health	Practical issues of the difficulties working with clients with schizophrenia in private practice

Emergent themes	Original transcript	Exploratory comments
Criticisms of the use of drugs	charities and actually when I was working at Mind, aside from the client, the schizophrenic client most clients that came there had been in the system for a long time for many years actually and quite often would demonstrate side effects of the drugs that had been taken which actually made them look even more abnormal. So if you think about some drugs used for schizophrenia one of the biggest side effects was tardive dyskinesia so if you think you're looking at someone who is going through this process of having a psychotic episode and throwing the side effects from a visual point of view the person can appear to be mad whatever that looks like	The drugs side effects give a misleading impression of people's lack of control – it's not madness, it's the drug. Sounds negative towards the use of drugs
	R: Yeah, the medical model is cruel [P: It is] *cheapest option* [P: I mean it's] *R: Don't you think drugs ever help?*	
Criticisms of the use of drugs	It think what drugs do do is flat line people and so even if you think of people that are depressed that are given antidepressants which are essentially now are described by GPs with no psychiatric intervention at all and I think they prescribe that willy nilly but anyway they are the drugs but designed to numb person's feelings so you will get clients that come in and say I am taking my drugs and I feel neither happy and neither sad and become dependent on the drugs and it almost becomes a situation where they are afraid to stop taking the drugs because of that terrifying feeling they had when they initially take, took the drugs, but my view is that again the option down two, two roads, your own journey, the one is to take medication, self-medicate through anti-depressants, never really coming to understand what brought you there in the first place, spending a life time going from one drug to another hoping that something is going to show up	Links drug effect back to depression. I wonder whether working with acute psychotic states would have let her see the necessity of those drugs for some patients in some situations. Critical of drugs prescription without proper assessment or therapeutic treatment

Emergent themes	Original transcript	Exploratory comments
Psychotherapy as a healing journey Participant's view of psychotherapy	and you are going to get better. And the toughest journey but probably the most rewarding journeys is to go through inner therapeutic process where you can really look at what brought you there in the first place and work through it and not that there is some magical solution at the end of it, because I think personally that life is a, a struggle anyway, there is never this continual lineal sense of being happy all the time because then but there is some kind of conditioning that we have particularly in the west that, you know, it's always about being happy and our goal is to always be happy whereas I believe that actually with everything in life there is an opposite force, where is happiness there is sadness and for me my work with my own clients is helping them understand their journey more without getting too esoteric and not necessary being a mental health problem but people happen, things happen in people's life that are traumatic where they do suffer loss, where for a number of reasons whether it is bad parenting, weak attachments, losses, whatever, we are all going to experience sadness throughout our life all the time, but I would see it as part of life and if we were to embrace it more and participate in the journey instead of trying to run away from it because it feels so uncomfortable I think you can find light at the end of the tunnel if you like. If you think about people who found wisdom or found sense of content within themselves I think those people are who've gone through that journey and at some point come out of the other end and I consider myself one of those people	Sees psychotherapy as a journey, understanding the reasons of distress – these thoughts are not specific to working with schizophrenia though. General thoughts on life journey and the purpose of psychotherapy. These thoughts are not specific to the client group diagnosed with schizophrenia though. Importance of shifting the focus: acceptance of suffering rather than running away from suffering
	R: We've gone through all the questions I had, is there anything else you thought I might ask and I didn't	

Emergent themes	Original transcript	Exploratory comments
	How was it for you, I don't know if I really answered everything? [*R: you did, yeah*] because [*R: Absolutely, very useful*] I guess the only thing I would request is I would like to read you dissertation	
	R: Yes, I will email it to you, hopefully it will be worth reading	
	Of course, why wouldn't it be?	
Difficulty in talking on feelings and responses to the client		Overall, in this interview the Participant had difficulty discussing her feelings and responses to the clients and reverted to talking about 'beliefs' and text-books.

PARTICIPANT 6 – MELANIE
Interpretative Phenomenological Analysis of the interview transcript

R: Text – stands for researcher's interventions
Bold – Notable quotes, used in the results section for illustration of the themes
Exploratory comments: Descriptive comments (normal text), Linguistic comments (*italic*), Conceptual comments (<u>underlined</u>)
Square brackets and italic within the transcript – descriptions of non-verbal communication and background sounds

Emergent themes	Original transcript	Exploratory comments
	R: So tell me about your experience of working with schizophrenia?	
	I think, I was thinking about it before you came in. I am not sure what's helpful in terms of your research because I was thinking about it from several different angles. I, I worked in my early training with several schizophrenic clients, one of my first placements as counselling psychologist but then I was also thinking about it from a slightly different angle that I worked with children in schools whose parents had been schizophrenic and I recently worked with a client in private practice whose mother was a paranoid schizophrenic and it just run through the family. Horrendous trauma in their past and this guy was pretty high functioning but a lot of the work was about his fear that he may, he read it all up, he was one of these people who google everything and know what the statistical chances were and I remember one day he came in convinced that he had schizophrenia. So I think about it from that, that I've seen it from different angels as well as purely just from the person but I am not sure what's helpful to know about?	Participant reflected on her work with clients diagnosed with schizophrenia but also considered how working with children of those diagnosed might be relevant. Although this was not the focus of my research I thought it would have been interesting to hear what she noticed about her reactions while working with people whose parents had schizophrenia.
	R: Everything	

Emergent themes	Original transcript	Exploratory comments
Steep learning curve	Probably better to do it chronologically then. I think, it was one of my first placements and I think somebody in training said often the most complex clients are seen by perhaps some of the least experienced people and I think sometimes that's true particularly in some of the sort of voluntary sector agency services like Mind and amm and that's not to negate the good work that they do. I think it's just the fact that people with those kind of presenting issues are likely to need long term therapy and that's not always available in the NHS so I worked in an NHS service in North London and I can remember my tutor saying, because it was older adults with severe and enduring mental health conditions, and at that time I think I just crossed the threshold of what the supervisor deemed to be the appropriate age bracket to work with this clients. So I got a placement there and my supervisor, my tutor said 'it's going to be really good experience because you work with these clients and then you go to primary care and your clients will get better'. And that was it; it was a very steep learning curve. At that time I had one placement working with children in a very deprived area and this one working in an NHS setting. I don't think it still exists although it was quite a wonderful service for these people because it was like a day centre, so that they could come, it was their lives really, they had meals there, they did art therapy. They did some amazing work and the guy who supervised the counselling service was very pro R.D. Laing, very into this sort of anti-psychiatry movement, quite a remarkable supervisor actually. But I think, I am trying to think, the first client I've got was psychotic, this, amm, the second client I've got so it's probably the second adult I worked with amm	Introduces me to the setting in which she worked. Observes the tendency that the least experienced therapists, often therapists in training, happen to work with the most severe cases Steep learning curve - started working as a therapist with clients diagnosed with schizophrenia. I assume her training did not prepare her to work with this client group (PsychD in Counselling psychology at City University)

Emergent themes	Original transcript	Exploratory comments
	R: What was it like with no experience to start off with psychosis	
Challenging client group Steep learning curve Being aware of one's thought processes Impact of lack of self-care Fear during initial meeting	Well, I think, I was talking about this to someone the other day actually, I think when you are going blind your fear levels are perhaps not so great as, you know, a friend of mine is working in Mind just now as a, he is not fully qualified yet, he's just been assigned a paranoid schizophrenic and **now as a professional I, <u>wooh!</u> [*Raises her voice*], you know that might be quite challenging**. I think I was just in this 'yeap, just do what you're given' and. This was one woman that comes to mind particularly, she was probably in her 60s and she was Greek and she had worked with several other counsellors in that service over the years. And they've all done it in Greek because a lot of City university students are Greek. So I was the first one who wasn't Greek and so that was a dynamic that was potentially going to be quite challenging. She had a very strong attachment to her last therapist but had sort of reached a stage that she felt wanted to try something else. So she did come and see me and that whole placement actually was a steep learning curve. I think initially if I am really honest I was very aware of my own thought processes, the impact it had on me in terms of lack of self-care, the fact that the room really smelled when she left, her hands were all yellowed, she was a chain smoker, quite overweight as well. And I think probably that initial, yeah, **if I am honest, initial meeting was a degree of fear** amm	Talks about her fear levels, is she now afraid to work with clients' diagnosed with schizophrenia whereas at the start of her career she did not know what to expect? *"Woooh!" - Sounds like she would think twice now whether to take on a client with such diagnosis or not.* Challenge. Is it about a need to defend against or ward off something? Is it about risk to the self or the client? Emotionally exhausting? Repeats 'steep learning curve' Is she <u>emphasizing that challenges of this client group or is it something about the running of the placement?</u> Impact of client's self-care on the participant: smell and appearance Fear of?
	R: Fear of what? Physical attack?	No, this is not what she is after

Emergent themes	Original transcript	Exploratory comments
Not knowing what to expect as a frightening experience	**Fear of not, not knowing what to expect**, I think. I think, I think it would be correct in assuming that most people when they start off with their first clients kind of had a sign above their head 'I haven't done this one before' but nobody knows that, but she, I remember this very clearly, I was thinking about this, she, she was very regular, she came to every session and I worked with her for a year and a half and I remember several things that kind of stick out for me amm, firstly initially how I negotiated the, for myself, I think the issues of some of the material that she was bringing amm, she was someone that believed that things were being built into her house, she was putting foil over things in the kitchen and there was a point that she moved area and she then sort of believed that she would be safe from these voices and then came along with telephone wires and certain, TV was a no go area as well, and some weeks it would be much more intense than other weeks and there was a real, in a way I worked to begin with quite Person-Centred with her because looking back on it now I think ultimately **the healing component was, for her was to have a relationship with somebody** and I think I really, **I struggled initially with the thought processes, kind of separating out my own reality to what she was talking about and there were moments where I felt a little bit disorientated to begin with**. And it was almost like, I had, to be able to to engage with her I had to step out a little bit of my own mind set. And by doing that while sort of keeping one foot in the present day it helped me to begin to get a sense of what her inner world was like. There was real, I remember there was real kind of personal challenges for me that I took to supervision because there was something, this was a woman that hadn't been believed her whole	Is this fear of not knowing what to expect just normal beginner therapists' fear? Does not seem to be specific to the clients with schizophrenia Describes the details of client work and the particular delusions of the client The value of psychotherapy for the client - the relationship The need to separate her reality from the client's Feeling disoriented (similar to Participant 3) The need to step out of her own mind set to be able to connect with the client Experiencing personal challenges.
Relationship with the therapist as a healing component		
Separating one's reality as a way of establishing connection with a client		
Disorientation		
Personal challenge for the therapist of how to respond		

Emergent themes	Original transcript	Exploratory comments
to the differences in perceiving reality Understanding and accepting client's reality as a way of strengthening the relationship	life and she was talking about these voices, and two would actually hear, it was a man's voice, no, it was actually several voices, there were different voices but they were all men's voices and she would keep saying to me 'You do believe me? You do believe me?' And that was a challenge in terms of how to respond to that whilst being kind of congruent to, I didn't feel it was appropriate for me to say 'no, this is your schizophrenia' because it seemed to me like that it was going to break the whole relationship and I think I sort of settled with 'I believe that's what you experience' and I think that helped to a degree. But I remember it was only about 3-4 session in and she, it's probably the only time it happened to me, she came in and she was really really angry and I had no clue what was going on [*laughs*] amm, she was quite angry and it was all about 'you don't understand what it's like' and she had been impacted by the war in Greece	About being congruent? Role of supervision Client demanding reassurance that her voices are real presented a challenge for the participant Understanding and accepting client's reality as a way of strengthening the relationship
Feeling lost and not knowing what to do Fear	so she started on this thing 'you don't know what it was like' and she got really hostile and quite aggressive and then she said standing up kind of quite close to me, I didn't feel physically threatened, **I felt 'I am not quite sure what to do here'** [*laughs*] and I was just quite honest with her, 'no I don't know what it was like but perhaps you can tell me'. She wasn't able to engage with that, I remember feeling quite fearful and she actually stormed out and I felt a little bit relieved I have to say, but then I felt and I told in supervision about, how to reengage her and how to talk about what might be going on, whether she'd come back and she did, she came back the next week. Turned out she actually had a row with someone at reception and it actually had nothing to do with me but she would not want to talk at all in	Not knowing what to do, feeling lost. Similar to Participant 1. *Laughter perhaps suggests that she was nervous or shy to admit that she felt lost.* Fear of not knowing what to do?

Emergent themes	Original transcript	Exploratory comments
Anger about psychiatric approach to dealing with clients	terms of what happened. Her ability to, I would say there were maybe 3 or 4 sessions that she was able to talk a bit about her history which was quite traumatic, she'd been impacted by the war, she had had very negative experiences in the NHS and I think that that was possibly something that helped to build her relationship, I remember she was on, I can't remember which medication it was, but one of the, antipsychotic medication and she was, typical things she didn't like the side effects was the weight gain, she felt slowed down and had to regularly see her psychiatrist and she came in and she was very angry because she wanted to talk to the psychiatrist about reducing her medication and the psychiatrist apparently had just given her two minutes and said 'are you taking your medication, are you going to counselling' and that was it. She felt extremely let down by that and I, I had a personal response, I felt quite angry on her part that, it's like she was treated like a number and I think with the support of the centre we were able to get someone else who was in the team, there were key workers to get another appointment and she went back. I think she felt very supported and contained by that and then she did make some quite big steps actually, she went and did an English language course, she got through the whole course which I thought was quite amm, so she made some steps, she had some very, she never talked about it, some very scary experiences as inpatient, she had, I remember it was on the assessment, she had broken her arm in a psychiatric hospital but she doesn't know how it happened and she	Client's experiences of being treated like a number by a psychiatrist Feeling angry on behalf of the client Offering additional support - psychotherapy is not enough for a client with multiple difficulties Feeling proud of her client's achievement?
Need to contain and limitations of such containment when a client	described an instant about some man who, but I think because of the mental state she was in it wasn't processed. Ammm, I think what else was striking, I think that initial thing that how do I, **how do I manage**	Need to contain the situation and client's emotions Inability to contain client's emotions

Emergent themes	Original transcript	Exploratory comments
is experiencing psychotic symptoms	**to firstly contain what's going on?** and **I think I kind of realised it's only to a degree you can contain sometimes when someone in that full-blown state.** How do I make sense of the symptoms for myself	Understanding client's symptoms as a way of grounding oneself
	R: How did you make sense?	
Making sense of the symptoms by acknowledging client's reality as different Affection	**I think by having to realise that her reality was very different** and it made me think about my grandma who started to suffer from dementia towards the, and she was convinced that people were stealing her dusters and teaspoons and I could see that that was real to her and I could see in this woman that this was very real to her and there were certain places in London that were safe to go, there were certain places that weren't because and there was something in this voice that linked right back to her experiences in Greece as a child. We tried to explore what the voice was like and she'd, it got quite disorganised and she, it became clear there was more than one voice but it was a Greek voice, which I always thought was quite interesting. Yeah, I must have worked with her for a year and a half, did she go into crisis? I think she went into crisis once, a lot of those clients were, either we were supporting alongside a crisis, yes, she was hospitalised I think for a week. But pretty much turned up to most sessions and by the end I actually felt quite warmly towards her and I remember our last session and she was quite upset that we finished, I was moving on placements and I remember her going up giving me a hug and it just seemed, it seemed appropriate at the time and I think that was her way of sort of showing her gratitude. In her own way she	'Having to realise' - Does the word "have" suggests she did not have a choice? What she perceived as a symptom was a reality for her client Symptom of a disorder versus reality? Hallucinations related to traumatic early life experiences Participant felt warmly towards the client Ending with the client and client's gratitude

Emergent themes	Original transcript	Exploratory comments
Holistic approach to treatment as a healing component (opposed to medical model)	came quite a long way, it is a bit of a revolving door. There were periods when she would stop taking her medication and I think this is what I saw in our service so much is that two steps forward one step back but I think it was quite a remarkable service in terms of the way it treated its service users, I think there was something quite healing in that for her as well being within a quite holistic environment where it was ok to be how you were, it was ok to have a bad day, there was company for them all	Reflecting on the course of treatment: 'two steps forward one step back' Reflecting on the service: supportive and holistic approach
	R: You mentioned before that you had to hold on to your reality or to separate your reality, tell me more about it	
Altered state of perceptions explained as countertransference Need to step out of one's reality in order to empathise with the client Schizophrenia as an alien experience	There were, I remember in the early sessions and **I think it was to do with transference as well, feeling sometimes just slightly spaced out amm, and kind of not quite knowing where I was**. **I took that to be a little bit what she was experiencing, there was something very, almost unreal**, because I had my very own, my own set of preconceptions of not experiencing things like being beeped through TV or my radio or, but yet she was telling me this very powerful story and I think I almost had to step a little bit more away from my own reality not in the state that I was totally but to, to allow me to enter her world and perhaps, perhaps a little more than some of other clients I worked with over the years because I think somewhere in me there was a degree of being able to relate to perhaps someone who is depressed or someone who is anxious little more than this which is quite alien to me at that time. **And it can feel quite in alien experience** I think particularly when I was at uni when I was a	(Was it only in the early sessions?) Participant is making sense of her experience in terms of psychodynamic theory - transference Spaced out, not knowing where she was, 'unreal' - unconscious / psychotic communication. Similar to Participant 3 Stepping out of one's reality Difficulty 'entering client's world' - is she talking about empathy? Inability to relate to client's experience Client's experience as being alien

Emergent themes	Original transcript	Exploratory comments
Viewing Relational approach to therapy as more beneficial to the client than CBT	trainee. I think I had another couple of, there was another client, she was one of my first ones as well she was psychotic and I worked with her for quite a while and she had been raped and she was in and out of the crisis service and she was a little bit easier to engage with because she was younger and, perhaps, hadn't had such negative experiences in the mental health system, which I think was a more of a protective factor for her, plus she had family, this older adult was completely alone. But I remember her talking about this [*inaudible*] no, images of rats pouring out of her and it seemed and then she would talk about having that same dream, it seemed to be very much linked to the rape and she was able to explore what happened on the evening. I think she had been drinking as well and I think she thought someone put something in her drink, not entirely sure but she could remember waking up and not knowing what had happened. She was able to engage a little bit more whereas I think with this older lady it was about me just building a relationship and I don't think, I think I would have lost her if I'd come in with a very CBT route of this is your schizophrenia talking because I don't think she could really acknowledge and digest that label, I had to be with her as a human rather than with someone with a label. I guess I worked with them in different ways and I think it also helped to, it helped me. I was talking to a client in my private work who, a lot of the therapy has been around the impact of growing up with his mother who was a paranoid schizophrenic and I remember when I first got this client and I took him to supervision, my supervisor is often two steps ahead of me which is always good but amm, she said you do realise that his greatest fear will be that he is going to become schizophrenic?	Recalls a story of another client Found easier to engage with Compares two clients with schizophrenia that she worked with and their ability to engage with her differed CBT approach with its labelling a problem is viewed as unhelpful with that particular client. Relational approach is viewed as more helpful. Talks about how it helped her. Not sure what she means - helped in her work with other clients who do not have schizophrenia? Goes on to talk about a client whose mother was

Emergent themes	Original transcript	Exploratory comments
		diagnosed. So did the work help her better understand how perhaps that client had experienced his mother?
Spending time with a psychotic person makes one challenge one's sanity	But that didn't come out until, he presented as quite depressed initially, quite high functioning, was living with his mother in this sort of family house he'd grown up in. He described there were three children of them having to take turns to sleep on the floor in the front room, she was convinced that bad spirit, a lot of that was around the religion for her, that bad spirits would come into the house, and just, it was very interesting to see how, how a young child would, you know, he was very young then, how that was his reality and how he could step out of that going to school and function as well as he did. But I do remember, it was very interesting, there was one week. I guess it'd be an undertone, of you know, he's one of these men who googles everything, he, he knew that there were risk factors i.e. there were several relatives that had schizophrenia, he'd smoked a lot of weed but I remember very clearly there was one session he came in and he described having these pains in his face and strains in his jaw and there were quite clearly symptoms of dissociation with him and I much more saw that as trauma related than anything like that but he came in and he was convinced that he had schizophrenia and it was a challenge to work with because I thought, I think if you give the assurances that actually you've got, I almost came from it like a sort of health anxiety issue that actually I, I couldn't say to him, and I couldn't definitively say to him so can I remember having to think on my feet and what. So he walked home after session, he googled things	Client's story Client's fear of developing schizophrenia Client's fear of going mad. Similar to Participant 2 who spoke about such fear

Emergent themes	Original transcript	Exploratory comments
	and he had ages in internet, he had convinced himself he has schizophrenia and I said ok well, what did you look at, he's got a mobile phone, shown me the sites he'd been on, ok and I looked through and I picked out the symptoms that were trauma related and not, didn't overlap with schizophrenia, well they were in the schizophrenia thing but kind of also be trauma related and I picked out the one's that he didn't have as well and we just kind of explored it but I can remember, I remember thinking gosh, how do you work with that because I knew I can give him all the assurances of the world but and it was really interesting because we left and there was something that felt very unfinished and I can remember thinking about it for some time after being, being a little concerned thinking had I missed something here because I was very much going down the view of it's not PTSD because he had other experiences later on in life as well and then he came back a couple of weeks later, he had taken pain medication and all the sensation was gone in his face in terms of the pains and that had been enough to convince himself that he hadn't got schizophrenia, so, that was interesting too in terms of the ongoing devastating effect it has on him, his mom is in and out of hospital but she doesn't, she doesn't care for herself, she's very overweight and him having to manage this with no social support and his own job.	Approaching this fear in terms of health anxiety Looking for evidence for and against his fear of developing schizophrenia Reassurances as unhelpful intervention Trying to make sense of client's problems, searching for a diagnostic framework to help her guide her thinking Client mistakenly takes the pain in his jaw as a symptom of schizophrenia Devastating effect of parent's diagnosis on the child leading to difficulties in his adult life
	So that was interesting as well and also working with young children whose parents, it's usually mothers, I was working in a, I was managing a counselling service I was working in a school. I remember there was one mother, actually I never got to meet the	Goes on to reflect on her experience of working with young children whose parents had multiple mental health issues

Emergent themes	Original transcript	Exploratory comments
Powerlessness and not being able to make it better for the client	mother, it was always the father and they were separated and it was the young girl, she sort of presented very much like a young carer and it was I think the need for consistency for someone like that in a world ever changing was just so important but I think as a professional, particularly working with a child **there was feeling of powerlessness of wanting to do something to make it better but not being able to**, I think I felt that with adult client as well, yeah, that' s kind of my, was there someone else I worked with? I have another interesting story, just a side-line but amm, I had a career as a professional ballet dancer and one of my friends in the last year, she's been dancing since she was 3-4 gone right through one of the vocational schools into a company in London and she stopped dancing and at the point of stopping dancing, her brother has schizophrenia, so it was genetic, something very strange happened to her and she, she never been like this before she started thinking that she could pick up vibes at people on the TV, she was going into ballet classes and she claimed that she knew how everyone was feeling and I do wonder how much of it was the stress of actually coming out of, and it wasn't in a therapeutic context but it was, it was concerning to me because I knew about her brother's history and I think even to this day she still watches her TV with sunglasses on because she thinks that will, but what I noticed with her is I remember we went out for lunch and **again I got that very similar feeling almost being in slight parallel universe that she was kind of talking but I wasn't, I felt quite spaced out**. What was interesting with her was when she started to reengage with dance in different ways like teaching and things her symptoms reduced. I thought that was a very interesting one, is she well now? No. Do I	Children of parents with the diagnosis: the need to be a carer from an early age Desire to help and make things better Powerlessness Example of a friend (non therapeutic context) who started to have psychotic experiences after ending her dancing career. <u>She assumes immediately that because her brother was diagnosed, schizophrenia was genetic in this instance, but they grew up in the same family. Nature/nature.</u>
'Being in slight parallel universe' 'Spaced out'		Feeling spaced out / in parallel universe. Experience of a non-therapeutic setting, yet very similar to the feeling she had when working with a client

Emergent themes	Original transcript	Exploratory comments
	think she might have problems along the line? Yes, possibly. And there were a lot of us trying to get her, to get support but she couldn't really see it	Self-expression through dance as a defence mechanism /protection against psychosis Wanting to offer support
	R: So dancing was her coping mechanism	
	I think probably very much so and I think it's a very much, I did my research on professional dance and one thing that came out was how dancers use such a nonverbal form of emotional expression and I think, actually I am thinking about this schizophrenic client that I worked with in a day centre a lot of that is really like the art therapy, again it's a very nonverbal form of, so. Yes, I think it probably was, I think it who she was as well, it very much becomes your identity, it's what you do since you are 2.5, it's not like I work in a bank, it's more who I am statement, but I thought that was that interesting to watch what must have been, she apparently started to lose it before that and I think people in the company had picked up very strange things that she was saying, yeah, but interesting	Dancing as a non-verbal form of emotional expression Noticing that people diagnosed with schizophrenia favoured non-verbal forms of self-expression such as art therapy <u>Loss of identity or threat to that loss as a trigger for the onset of psychotic symptoms</u>
	R: What was it like for you to speak to your friend or client, when you hear this and you understand that it's not quite your reality, what do you notice about your reactions? Like you said you feel spaced out ...	With this question I tried to bring her back to her immediate reactions when in the room with a client
Desire to help (protectiveness)	I think it was different with, like with the client that I saw whose mother was sch, I think there was part of me that wanted to help, there was part of me that wanted, she had very little support, to kind of sign	Desire to help by engaging social

Emergent themes	Original transcript	Exploratory comments
Desire to help as response to sensing person's vulnerability Powerlessness Lack of steady progress as a challenging aspect of work Curiosity and wanting to know clients story 'Symptoms are getting in the way' Repulsion as limiting therapist ability to 'see the person underneath'	post him to kind of get the support from the social services. I wanted to, I wanted to take care of the relative actually and he was my client ultimately. So it was about making space for him in amongst the chaos of his mother. I think I probably had the same reaction with my friend as well and actually seeing other friends do the same thing, you know we tried to get her to go to her GP; there was that kind of desire to get help early, particularly with somebody like that in terms of. I would say that with all of the clients I worked with I've had a sense of powerlessness to a degree. And I think that's something that in a way you had to sit with and it was difficult initially watching these clients particularly in the severe mental health setting, just think they are getting somewhere and then something happens and back, you know, so challenging, certainly never dull. I guess also curiosity as to, I mean I'm quite curious in terms of their early experiences and how they ended up where they ended up, so I think curiosity to perhaps explore more their life story, but often the symptoms are getting in the way of being able to do that. A lot of was more kind of symptom management really, because this, particularly with the the NHS setting the symptoms were really big in the room and that was what she would bring, all those stories about but I could see it distressed her and I think that was the bit that, don't know, something about had this initial kind of, I don't know, just the sense of the way she dressed, the fact that she smelled aammm, but I think over time I was much more able to see the person underneath all those. Do remember having to open the window when she left [*laughs*] and that was the first time I started using alcohol hand wash ammm, a lot of the clients there; self-care was an issue, things like that. I don't know if I answered	services and taking care of the relative Wanting to help by recruiting extra help, GP etc. Sense of powerlessness Lack of steady progress. She said 'difficult to watch ...' - sad, annoyed, angry? Challenging Curiosity, desire to understand Symptoms as a hindrance Smell and appearance evoking repulsion

Emergent themes	Original transcript	Exploratory comments
	your question?	
	R: Yeah, yeah. How do you make sense of schizophrenia?	
Biomedical model's limitation in explaining the experience of schizophrenia Schizophrenia as an alien experience Medical versus existential view Schizophrenia as the unknown and limitations of intellectual understanding Sitting with the unknown as a way of working with this client group	I think it's a really interesting question because I think it can be looked at in so many different ways and I think, perhaps, as professionals we look for the very scientific, you know, it's genetic or it's imbalance in terms of brain chemicals, all those studies that show that their brains are slightly different and that may be the case but does that really help to make sense of it and can someone who has never experience that [*inaudible*], I doubt that they can. I think they, perhaps, can make sense of the symptoms and understand why they are the way they are, but in terms of this subjective experience of somebody going through that, in some way I would be doing them a disservice by pretending I did know what it was like. And it's a tricky one as well because I think a lot of the clients that I worked with had struggled with the diagnosis of schizophrenia and very often it wasn't, it was never brought into the room, this is what they are presenting with and I think there is something very much working with the human and I think that was what was so great about that service because it was very, you know, clients had their medication but there was very anti-psychiatry, it was much more kind of R.D.Laing on that line of things. So **I can make sense of it from an intellectual perspective in terms of knowing what the typical predisposing things are that might lead to it. I think in a way it's actually sitting with the unknown and I think**, I think about	Biomedical explanations do not help to make sense Limitation of theories and knowledge? Inability to understand the subjective experience of people with schizophrenia Preserving the otherness of the other is a way of showing respect to the client? Clients struggling with the diagnosis Working with the human: existential perspective Intellectual understanding Sitting with the unknown as a way of working with this client group

Emergent themes	Original transcript	Exploratory comments
	R: Is it the difficult part sitting with the unknown?	
Schizophrenia as an alien experience	So I just try to think about in terms of perhaps other diagnosis I worked with amm, and if it's different in some ways? Possibly, just trying to think on my feet here, a lot of the typical presenting issues that I may see or have seen during my training and my professional career there is something within that experience that is tangible that I can get to a degree, **I can get perhaps to a degree what it might feel for someone who has a panic attack or to a degree to what it might feel like to feel depressed or to struggle with an eating disorder but can I do that with someone with schizophrenia? I think the answer is 'no'.**	Alien experience, intangible, 'can't get'
Schizophrenia as chaos	I think the only other parallel I can be, it is quite interesting actually, the more sort of neuropsychological symptoms, learning disabilities but again **I think within the literature, within what's written it's very medicalised models of this is typically, is very symptoms based amm perhaps that's how professionals manage the, the unknown, is to try and create some structure amongst what can be chaos I think**. So I think the only, I think there are a lot of presenting issues which I think I can, I can grasp something of if anything yes I know what it's like not having a great day or I know what it's like to feel a bit anxious or but with that is, is kind of different I guess and I think it would be more like. I mean I worked with a few clients with learning disabilities and knowing how much, yes with someone say with anorexia there will be denial and there will be that but this, there is something different perhaps with learning	Compares schizophrenia with learning disabilities in terms of her difficulty to understand the experience An attempt to create structure amongst chaos The word 'chaos' was mentioned by Participants 2 and 3 Compares alienness of schizophrenia

Emergent themes	Original transcript	Exploratory comments
‘It’s all about finding a way in’ (can be used as title of a theme?) Establishing a connection with the client rather than treating the symptoms Fear in general public	disabilities, schizophrenia, psychosis and other forms of psychosis. That you are not quite sure who, you know, how it’s being received and I think back to a supervisor of mine is, is, every supervisor leaves you with a germ or something, but another supervisor saying **‘it’s all about finding a way in’ and I think, I think that’s how I would make sense of working with schizophrenia, I need to find a way in to connect with a client as a human being, not, not just to see them as a set of symptoms and I think that’s something that can, can get missed** and I think it doesn’t do people with schizophrenia, it’s not useful for them some of the ways it’s portrayed in the media. I think you see the kind of news headlines, the images of so and so absconded from unit murdering this, you know, the whole idea rehabilitation in the community and how that evokes fear in some people and I don’t think there is enough, I think it’s now, I think things have shifted a lot in terms of depression, eating disorders, anxiety it’s kind of a little bit more ok in society. I think things like schizophrenia are still, I think if you asked most of the general population would be probably quite fearful. Kind of interesting to know what comes to mind if you sort of ...	to an experience of learning disability Fundamental task is to establish a connection with a client Set of symptoms versus a client as a human being Portrayal of schizophrenia in the media Fear of schizophrenia in general population
	R: Are you fearful?	
Initial fear of clients before establishing a relationship with them	Am I fearful? I think I, I**, was I fearful of the clients that I worked with? Possibly initially until I’ve got to know the human part**, amm, am I fearful in community? It’s a tricky one because I just come out of the service where there is domestic abuse where actually quite a lot of the perpetrators did have a mental health diagnosis and I saw, I	Initial fear until getting to know the ‘human part’ Until they show their vulnerability? So is it the defences with which they try to protect themselves that evoke fear?

Emergent themes	Original transcript	Exploratory comments
	saw the other side of that and I spent a year and a half reading pages and pages of social services case chronologies, of court reports or some of the most horrendous things that happen to women and children. So, I don't think schizophrenia can be used as s sort of blanket, I think there are, there probably are some people with schizophrenia that is, it's kind of ok to be fearful because they are so unwell and perhaps it isn't safe to be around but it's, there is a spectrum I think and I think everyone has got to that stage for a reason and deserves to have the help that's right for them. I am thinking about more of my work with domestic violence now. Gosh, yeah, I am thinking of one case in particular where he was pretty, we didn't take the case on initially because, very often what we'd see is that police would force these women to go into court and perpetrator gets two months! And then he is extremely angry he comes out so I remember this one case and he did have a complex mental health, schizophrenia as well so he came out and then he was sectioned immediately after coming out but then he was roaming streets. And I just remember this woman and this little boy they were completely, they, as soon as he came out jail they [*inaudible*] house, they moved the family but I remember that, you know, the terror that that woman is experiencing knowing, not knowing where he was and usually we would encourage women to change their phone numbers but for her it was almost like a protective factor knowing, was he in hospital, was he sectioned, she did have some communication, in a way I thought she had to a degree. But then he, we did eventually take, I am laughing, but it's not really funny, we did eventually take the little boy into the service because he was then attacked by his own father	Reflects on her experience of working with domestic violence Similar to Participant 5 who thought that an additional diagnosis is required in cases of antisocial behaviour Remembers a case where the perpetrator was also diagnosed with schizophrenia

Emergent themes	Original transcript	Exploratory comments
Fear of violence as opposed to fear of clients diagnosed with schizophrenia	with a hammer and was obviously back into prison. So I think I've seen the other side of, the more, I think it's a spectrum like everything, is mild depressions, you know. I think there are some people that are extremely unwell but that, you are asking me if I am scared of schizophrenia? I don't think I am scared of it in terms of a blanket and I think if I can find a way of connecting with that person then it makes life easier but I have seen the far end of the spectrum that. Would I want to work let's say in a forensic setting, I just know it's something I couldn't do. Would I want to work with that man I just described to you who was roaming the streets and? The answer is probably no. It would not be the right setting, he needs to be in a secure setting	Fear of aggression and violence rather than people with schizophrenia
	R: What about in you private practice here if you received a phone call and you knew that person had schizophrenia?	
Limitation of private practice as a setting in terms of offering the support the client needs	It's an interesting question because it's something that more generically I talked about with my private supervisor because a lot of my work here is Friday afternoons and evenings and Saturdays so whilst I always have the names and contact details of GPs it makes life more complicated because it tends to go out of hours so I think in private work I am a bit more. Would I feel safe to, in terms of physically safe, probably yes, I know quite a number of people who work here. Would I feel safe to be able to contain that and to, I don't think it would be the right setting for them to be honest, I think they need to be imbedded more in a multi-agency response where they have access to a psychiatrist and it's something I talked about a lot	Working in private practice she would not want to work with clients diagnosed with schizophrenia Would feel physically safe

Emergent themes	Original transcript	Exploratory comments
Need for joined help process in terms of setting for therapeutic work	around borderline client as well and my supervisor, I think through her own experiences has kind made a comment that she is not going to see borderline clients in private practice because of some of the things that she encountered. I think here, I mean I always ask myself when I meet a client 'Am I the right person, can I work with this, is it?' I do tend to go for sort of worried well, I have to say. Would I work with a schizophrenic client in private practice? Probably not in this setting no, because I don't feel I would be doing them the service that they need. And it's interesting this because I think about my friend who is working at Mind and I think this guy is in some kind of sheltered housing but this, he was talking to me about, and he comes, usually somebody brings him to the sessions, he can't stay for the whole session but there is something, and I said this to him, there is something missing there because there isn't joint up working because there is whole lot of things that he doesn't know, the assessment was not very thorough and I am saying do you know this? Have you spoken to them, do you know why are they bringing him, are there risk factors? And there is something very much missing for me in terms of the joined help process which I think needs to be around for that kind of work. So no, I don't think I would see somebody in my private work, for their own, for their own safety and also because I don't think that's the best support for them.	Need for multidisciplinary team setting
	R: If you were to give advice to a therapist who is working with schizophrenia what would that be?	
	Obviously to have a good insight into, in terms of making sure that	The need to take a thorough client

Emergent themes	Original transcript	Exploratory comments
Importance of taking a thorough client history Importance of establishing an emotional connection with the client In light of mistreatment in the medical system there is a huge need to be human with this client group Importance of an accepting relationship	you know and this is tricky with schizophrenia because their mental state they may be when you get them but, to get as much history as you can, I think that was very interesting in terms of the Greek client and the voices being in Greek, you know, there is something there that was quite interesting for me in terms of her history. To have as much as possible, I mean most of these people would have been in the mental health system for some time to have as much history as you can but to not let that totally guide the therapy to, to try and find a way in to connect with the client and I think because I've seen particularly in that setting the way some of these clients were treated by psychiatrists and things that I, there is a huge need to be very human with these people because they deserve the respect perhaps at times they are not given. And I think and it fits quite well with the philosophy of counselling psychology in terms of really trying to get sense of what their subjective experience is, how the symptoms affect them, I think perhaps some clients might be a bit open to a more CBT approach, it depends on where they are at but if it's been engrained for years and years and years I don't know, I am thinking back to that woman, you know, actually there were changes there, did I actually directly challenge her voices? No I didn't. There was something else about it being ok and I guess that sort of fits with how perhaps how people work with psychosis is not about getting rid of the voices, it's about what they mean and not having them, and I think maybe me being able to sit with her, her distress and her voices, and all the thoughts that she had around them.	history The need to connect with the client Need for respect Focus on the subjective experience Understanding the meaning of the symptoms Acceptance of the client
	Perhaps in a way I did the same thing by kind of making it ok that	The role of the relationship

Emergent themes	Original transcript	Exploratory comments
	perhaps it wasn't so terrifying and perhaps so isolating. I think it's a huge thing about isolation for these people and I think that's in a community as well. I think also, it really depends on the client but I think the family need to come into it, now they may have no family in which case it's something very different but having had the other experiences on the other side of actually schizophrenia has a devastating effect on the whole family. And actually a friend of my mom's son recently committed suicide and he had schizophrenia. She knows her through golf, it's quite interesting because the daughter was training in psychology and she had just about to start on the clinical psychology course and her brother had committed suicide with schizophrenia and she was doing a PhD in health psychology and her research was linked to schizophrenia and I can remember thinking this is not the right time for you to start a clinical course, although I haven't met the person but thinking, Gosh how do you, particularly with clinical psychology works [*inaudible*] you do, the first placement she got was severe mental health and she really apparently struggled with, other people's on the courses perceptions of it and jokes were made because you know that was her brother and I think she had to take a year out but she is still doing the course but I think that's interesting as well in terms of comments that can be made in that, within the mental health system I mean people say things sometimes just as a way of managing their own feelings around things but I think there needs to be a huge degree of sensitivity and particularly I think there is a real need for support for relatives as well because if as professionals we find, can't make sense of it how does, how does somebody else. So I think there is something there in terms of I know	Isolation as an important issue for people with schizophrenia The impact of schizophrenia on the family Example of a family friend The need for sensitivity around schizophrenia Learning about schizophrenia from a subjective point of view Limitation of statistical manuals and
The need for sensitivity around schizophrenia		
Subjective experience as a		

Emergent themes	Original transcript	Exploratory comments
way of understanding schizophrenia The impact on the family	things like Mind they do some kind of psycho-educational leaflets but they are very geared around symptoms rather than I think that and maybe there is out there because I, you know, schizophrenia is not my key area but if there something to be learned from my own experiences is something that is written much more from a subjective point of view, it's not a DSM, delusions this, that, it's kind of meaningless. What it feels like and I think some of the project they've done around art with schizophrenia are really interesting because I think it's a way of perhaps accessing what we can't access but I think more, probably more for the relatives and more for the general public you know what it's like to live with someone with schizophrenia, what it's like to feel that powerless, what it's like to see someone going in and out of hospital, the frustration they must feel when they stop taking their medication, side effects. What it is that the and it depends whether the person with schizophrenia is in that moment but what is it that they feel they need? Not something that is imposed on them like drugs and challenging the voices and bring the human back into it.	theoretical knowledge about the symptoms Powerlessness, frustration Treatment: the need to 'bring the human back into it'
	R: Would you work in a psychiatric hospital?	
	Would I? Probably, probably, it depends what you mean by psychiatric hospital because there so many different, because obviously I worked with [*R: with inpatients who are schizophrenic*] I don't think it would be an area I would chose to go into. I have a colleague who works [*R: why not?*] I wouldn't choose to go into? No [*R: why?*] because I don't think it would be something that I would	Inpatient setting would feel too much.

Emergent themes	Original transcript	Exploratory comments
The prospect of working solely with clients diagnosed with schizophrenia in an inpatient hospital setting feels intense and 'too much' Chaos is unbearable	want as a sole focus perhaps, perhaps that would feel too much for me, I don't know, I don't know whether it is so much purely about schizophrenia as such as would I want to work in a setting like that is only inpatients unit so almost like sort of A&E of psychology because anything can kick off at any point and I just don't see for me it's a setting I would want to work in, you know I can work with severe tr, I guess working with domestic violence risk assessing these moms, but it felt I don't know maybe there is something just for me that because I keep getting these local agencies, because there is a local agency and they keep giving me opportunities to work in youth offending and there is again there is something not quite [*inaudible*] settings but I think as psychologists we have to find out what we can't work with, and again I think it's like perhaps one of my colleague who works purely with trauma, I often wonder is there a lifespan of that? I think it's a similar thing for me with working in in[patient], there are some good points because you've got a multiagency team, you probably got more support than, and you need that, than perhaps some other setting but some of the stories that my friend has told me about this inpatient unit and I don't know what just becomes normal which is so not normal, people trying to set it up that they would be, someone was trying to set up in a room that when a nurse opened the door it would cause the cord around their neck, cause them to hang themselves. Just weird things, it's just not for me, yeah, I don't know **something about that chaos feels too much**	Is it about the people with schizophrenia or about the setting itself? The unpredictability of the inpatients unit. <u>Is there a lifespan of working with schizophrenia as well? 4 out of 6 participants chose not to work with these clients</u> Normality of extreme situations, human tragedy becomes the norm Chaos
	R: Well, we've gone through all of my questions is there anything else you thought I might ask and I didn't?	

Emergent themes	Original transcript	Exploratory comments
Schizophrenia as the unknown Use of labels as an attempt to capture an experience that is difficult to capture	Ammm, I guess I am trying to think, remind me the purpose of your research again, what is it you are trying to, is it the subjective experience of therapists? [*R: Yes*] I am actually thinking back to my own research and something that, a question that elicited really rich data for me and I am trying to apply it to this to see, if I applied it to this the question would be when I say the word schizophrenia what comes to mind? And I'd encourage them to think of thoughts, images, particularly the imaginary staff it illicit some rich data [*R: Would you mind doing the same?]* No, I am just trying to think on my feet as to how I would respond to that. And I think it would be a really interesting one in terms of what the general public would say as well and whether people within different therapeutic modalities, different settings would come up with different things, say clinical psychologist who is working with CBT versus a psychotherapist, I think there is some rich material there. From my perspective, the unknown, I get images of working in that severe mental health setting but then I actually felt quite contained, quite safe, I have thoughts of how it's portrayed in the media, perhaps something that is very hard to comprehend. I think part of my head goes to more diagnostic criteria but I wonder if perhaps as professionals we are more drawn to that because it is the only way we can make sense of what can't be made sense of and I think the other thing that comes to mind some of the things you see online in terms of the art work that people have done perhaps that's a way of capturing it which is different. I don't think there are words to capture something like this. Perhaps that way we fall back on labels sometimes. I don't know whether that helped?	Immediate associations to the word 'schizophrenia': the unknown safe and contained mental health setting fear portrayed by the media difficulty comprehending diagnostic criteria art work Difficulty to capture the experience in words leads to the use of labels

Emergent themes	Original transcript	Exploratory comments
	R: excellent questions actually	
	Yeah, the imagery was very, certainly very powerful in terms of that yeah	
	R: Well, thank you very much, it was very useful	
	You are welcome	